

PART 6

PAYMENT FOR SERVICES

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6000. INPATIENT HOSPITAL AND LONG-TERM CARE REIMBURSEMENT -GENERAL

Since it was enacted in 1965, the Medicaid law has required each State to have an approved Medicaid plan to pay for inpatient hospital services (section 4.19(a) of the State plan), and skilled nursing facility (SNF) services, (section 4.19(d) of the State plan) to individuals eligible for those services under the plan. In 1971, P.L. 92-223 added intermediate care facility (ICF) services as an optional Medicaid service. SNFs, ICFs, and intermediate care facilities for the mentally retarded (ICFs/MR) are known collectively as long-term care (LTC) facilities.

The Omnibus Reconciliation Act of 1980 (Public Law 96-499), which was enacted on December 5, 1980, made a significant change in the provision of the Medicaid law that governs payment for LTC facility services. Specifically, section 962 of Public Law 96-499 amended section 1902(a)(13)(E) of the Social Security Act. It deleted the requirement that States pay for LTC facility services on a reasonable cost-related basis, and replaced it with the requirement that States pay for SNF and ICF services through the use of rates (determined in accordance with methods and standards developed by the State) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide care in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Section 962 also requires the State to make further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each LTC facility, and for periodic audits by the State of these reports. The effective date specified for this amendment was October 1, 1980.

On August 13, 1981, the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) was enacted. Public Law 97-35 made several significant changes in the provisions of the Medicaid law that govern payments for inpatient hospital services. Specifically section 2173 of Public Law 97-35 removed the requirement that States pay for the reasonable cost of inpatient hospital services and instead incorporated the requirements for LTC facilities as amended by section 962 for both inpatient hospital services and LTC facility services at section 1902(a)(13)(A) of the Social Security Act.

It should be noted that the primary objective of Congress in enacting sections 962 and 2173 was to increase the States' administrative and fiscal discretion to set payment rates, by keeping the Federal regulatory and other requirements to a minimum level necessary to assure proper accountability. The statute requires that the State make a finding that its payment rates are reasonable and adequate to meet the costs of efficiently and economically operated facilities. Although a State may use budgetary considerations in setting their payment rates, the State must make a finding that the resulting rates are reasonable and adequate as required by the statute.

6001. STATUTORY REQUIREMENTS

The statutory basis by which inpatient hospital and LTC reimbursement plans are reviewed is found at sections 1902(a)(13)(A) and 1902(a)(30) of the Social Security Act. Section 1902(a)(13)(A) mandates that a State plan pay for "hospital, skilled nursing facility

and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)) for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports."

In addition, section 1902(a)(30) of the Social Security Act mandates that a State plan for medical assistance must, "provide such methods and procedures relating to the utilization of, and the payment for care and services available under the planas may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy and quality of care."

6002. REQUIREMENTS NECESSARY FOR STATE PLAN SECTIONS 4.19(a) OR 4.19(d)

The regulations at 42 CFR 447.252 require that a State plan for payment of long-term care facility and inpatient hospital services must include the methods and standards used by the State to determine its reimbursement rates. The State plan must be comprehensive enough to allow interested parties an understanding of the ratesetting process and the items and services that are paid for through these rates. This requirement for the comprehensiveness of State plans is consistent with the regulations at 45 CFR 201.2. That regulation, as specified in the State Medicaid Manual (§13025), requires that the State plan be a comprehensive statement describing the nature and scope of its program. The State plan must contain all information necessary to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.

The regulations at 42 CFR 447.253 in conjunction with 42 CFR 447.255 require that the State submit assurances, related information and publish public notice whenever the proposal represents a significant change in the methods and standards for determining payment rates. A State's determination of the significance or insignificance of plan changes must be based on a test of reasonableness. The State's determination of significance should not only depend on the amount the State's expenditures increase or decrease because of the changes. The determination of significance depends also on the impact the changes submitted by the State would have on the State's methods and standards.

Where changes are insignificant (e.g., minor changes to the language in the plan, procedural changes, and technical changes), the State is not required to submit assurances and the related information. The State, however, must submit a statement to HCFA indicating that the plan amendment is insignificant in order to document that the revision is considered insignificant for Federal review purposes.

6002.1 State Assurances and Findings.--HCFA approval of a State plan amendment is based on compliance with all Medicaid requirements set forth in the law, regulations, and program instructions. You must find and assure HCFA that its rates meet the statutory requirements. Also, submit the related information pertaining to the payment rates as specified in 42 CFR 447.253 and 447.255.

The assurances and findings requirements, as specified in 42 CFR 447.253, for purposes of such Federal review, are as follows:

- o Make a finding and satisfactorily assure the Secretary, that it pays for inpatient hospital and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- o Make a finding and satisfactorily assure the Secretary, that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital or long-term care facility services than the amount that the agency reasonably would be paid for such services under the Medicare principles of reimbursement. (See §6005.)

- o In addition, specifically with respect to inpatient hospital services, satisfactorily assure the Secretary, and make a finding, that:

- The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

- The methods and standards used to determine payment rates provide that reimbursement for hospital patients receiving services at an inappropriate level of care, under conditions similar to those described in §1861(v)(1)(G), are made at lower rates, reflecting the level of care actually received, in a manner consistent with §1861(v)(1)(G).

- The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

You must make all of these findings whenever you make any plan change subject to HCFA approval. In addition, in the absence of any plan changes, you are required to make the findings annually but are not required to submit the annual findings to HCFA. Instead, HCFA monitors such documentation as part of program oversight activities (e.g., SPECTRUM reviews).

You must also assure that you:

- o provide individual providers with an appeals or exception procedure as specified in §6006;

- o provide for the filing of uniform cost reports by each participating provider;
- o provide for periodic audits of the financial and statistical records of participating providers;
- o have complied with the public notice requirements as specified in §6004; and
- o pay for inpatient hospital and long-term care services using rates determined in accordance with methods and standards specified in the approved State plan.

6002.2 Related Information and State Plan Requirements.--Submit with the assurances listed in §6002.1, related information to support those assurances. The related information, as specified in 42 CFR 447.255, is as follows:

- o The amount of the estimated average proposed payment rate for each type of provider (hospital, SNF, ICF, or ICF/MR), and the amount by which that estimated average rate increased or decreased relative to the average payment rate in effect for each type of provider for the immediately preceding rate period.
- o An estimate of the short-term and to the extent feasible, long-term effect the change in the average rate will have on the following:
 - the availability of services on a statewide and geographic area basis,
 - the type of care furnished,
 - the extent of provider participation, and
 - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

You may submit quantitative data to enhance your assurances if you wish to do so.

Finally, the State plan requirements of 42 CFR 447.252 must be met:

- o The payment methods and standards consistent with 45 CFR 201.2 must be included in the plan and presented in reasonably comprehensive detail.
- o If you choose to apply the cost limits established under Medicare on an individual provider basis, the plan must so specify.

6002.3 Requirements for Submission of State Plan Amendments for Payment of Nursing Facilities Under Nursing Home Reform Requirements of Omnibus Budget Reconciliation Act of 1987.--

A. Background.--Section 4211(b)(1) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) amended §1902(a)(13)(A) of the Social Security Act to require States to incorporate into their State plans for payment of nursing facilities, adjustments to their payment methodologies for the nursing facilities' costs of complying with the nursing home reform provisions of §1919. Specifically, these provisions require States to submit amendments to their nursing facility payment plans by April 1, 1990, which are effective October 1, 1990, and provide assurances satisfactory to the Secretary that their payment rates take into account the facilities' costs of complying with new subsection (b), (other than paragraph (3)(F) thereof), (c) and (d) of §1919. These provisions of §1919 provide new requirements concerning the provision of services, residents' rights, administration and other requirements for nursing facilities.

Section 4211(b)(1) of OBRA 1987 also adds §1902(a)(28)(C) of the Act to require State plans for Medical Assistance to establish procedures for making available to the public the data and methodology used in establishing payment rates for nursing facilities under Medicaid.

This provides instructions for States to submit amendments to their State plans for these new requirements.

B. General Requirements.--Modify your plan to account for the following. Under §1919(a) of the Act, the distinction between ICFs and SNFs has been abolished and Medicaid no longer covers two separate levels of institutional services, either in separate facilities or in one dually-certified facility. The new statute provides for only one type of nursing facility care and only one type of nursing facility. Accordingly, while States may develop payment systems for these facilities that are based on their case mix, they may not create facility distinctions or classifications by level of care as a means of varying payment rates.

Section 1902(a)(13)(A) of the Act, as amended by §4211(b)(1) of OBRA 1987, requires that payment rates to nursing facilities, as of October 1, 1990, take into account the additional costs incurred by facilities in complying with the requirements of OBRA 1987. You are not permitted to maintain existing rates and provide for retrospective increases for costs incurred in complying with the requirements in §1919(b), (c) and (d) of the Act. However, you are permitted to use retroactive adjustments in your methodologies as long as interim payments, as of October 1, 1990, take into account the additional costs. It is immaterial whether the October 1, 1990 payment rates are determined on a prospective or retrospective basis as long as the specific methodology adopted complies with the statutory requirements.

General cost categories under §1919 of the Act include: continuing education for nurse aides; nurse staffing requirements; other staffing requirements (e.g., dietician, pharmacy, dental, medical records, activities personnel, social worker); resident assessment; plans for care; resident personal funds; and residents' rights.

C. Submission of State Plan Amendments, Assurances and Related Information.--Section 4211(b)(2) of OBRA 1987 requires States to submit by April 1, 1990 amendments to their State plans to provide for an adjustment in rates effective October 1, 1990. The statute further requires HCFA to review each amendment and, by September 30, 1990, to approve or disapprove them. The statute provides that the absence of approval does not relieve the State from any obligation or requirement under title XIX of the Act.

In meeting these requirements, submissions of State plan amendments for nursing home reform payments must include the following:

- o The assurances and related information currently required by 42 CFR 447.253 and 447.255 for State plan amendments. (See §6002.)

- o The additional assurance that the rates to nursing facilities, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of §1919(b) (other than paragraph (3)(F) thereof), (c), and (d).

- o A comparison of the differences in your former facility certification requirements and the new requirements for nursing facilities, effective October 1, 1990.

- o A detailed analysis of the cost increases to be incurred by nursing facilities in meeting each of the new requirements. This analysis must include the methodology you use to make the required estimate, the specific cost data used, and the expected impact on the cost increases of any facility waivers you may grant under §1919(b)(4)(C)(ii).

- o You must demonstrate how these estimates of the additional costs incurred by nursing facilities in complying with the new requirements are accounted for in the proposed payment rates. You may provide lump-sum payments for one-time and start-up expenses outside of the proposed payment rates.

- o Summarize the public comments received concerning your proposed methodology and the data utilized for the adjustments.

D. HCFA's Review Process for Plan Amendments Concerning Nursing Home Reform Requirements.--Amendments to §4.19D of a State plan resulting from OBRA 1987 requirements are reviewed in accordance with HCFA's existing review process. Amendments, along with the assurances and related information described in subsection C must be submitted to the HCFA regional office no later than April 1, 1990. HCFA reviews your submittals expeditiously and approves the amendment or requests additional information from you. If additional information is requested, submit your response no later than July 1, 1990 to permit sufficient time for HCFA to review the response prior to the October 1, 1990 effective date. If the amendment is disapproved, you are required under the statute to submit immediately a new amendment meeting the statute's requirements. The absence of approval does not relieve you of any obligation required under title XIX of the Act.

HCFA's review of State plan amendments is based on the acceptability of your assurances and related information. HCFA focuses particular attention on your assurance that the payments take into account the additional costs incurred in complying with the new requirements. Specifically, HCFA reviews in detail the data and methodology used in estimating the facilities' costs of complying with each new requirement and how these costs have been taken into account when setting Medicaid nursing home rates.

E. Effects of Nursing Home Reform on Medicare Reasonable Cost Principles.--Medicare reasonable cost principles reflect the additional costs resulting from the OBRA 1987 requirements. Therefore, there is no change in the upper payment limit assurance requirement as specified in 42 CFR 447.253(b)(2).

6002.4 Effects of OBRA 1990 on Nursing Home Reform Requirements of OBRA 1987.--The following are interpretive guidelines for States in submitting their plan amendments due by April 1 of each year.

A. General Requirements.--The new statutory language added to §1902(a)(13)(A) of the Act (i.e., "the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title") requires States to submit an assurance that their State plans provide for payment of nursing facility services through the use of rates that take these costs into account. This assurance must be submitted at least annually. If you cannot assure HCFA that your plan already takes these costs into account, you must modify your plan to do so.

The new requirement added by §4801(e)(1)(B) requires that you include a detailed description of your specific payment methodology in your plan. If this methodology is not currently included in your State plan, you must submit an amendment to include it.

B. Submission of State Plan Amendments, Assurances and Related Information.--Section 4211(b)(2) of OBRA 1987 requires States to submit (by April 1 of each year) amendments to their State plans to provide for an appropriate adjustment in rates, effective October 1 of that year. The absence of an adjustment in payment rates in a particular year does not relieve a State from the requirement to submit a plan amendment by April 1 of that year. The statute further requires HCFA to review each amendment and, by September 30 of each year, to approve or disapprove it. The statute provides that absence of approval does not relieve the State from any obligation or requirement under title XIX of the Act.

If your State plan does not contain a detailed description of the specific methodology used in determining the additional costs incurred by facilities in complying with the nursing home reform requirements of OBRA 1987, you must submit a plan amendment which includes a description of the payment methodology. It is not necessary for you to include the specific cost categories identified in §6002.3 in this methodology. However, whatever payment methodology is used must take into account the additional costs incurred in complying with the OBRA 1987 and OBRA 1990 requirements. In addition, you must submit an assurance that your State plan provides for payment of nursing facility services through the use of rates that take into account the costs of complying with the nursing home reform requirements of OBRA 1987 and OBRA 1990.

By April 1 of each year, you must submit a State plan amendment that provides for an appropriate adjustment in rates effective October 1 of that year. This plan amendment, which includes any necessary adjustment, must account for the costs of nursing home reform.

C. HCFA's Review Process for Plan Amendments Concerning Nursing Home Reform Requirements.--Amendments to §4.19D of a State plan resulting from OBRA 1987 and OBRA 1990 requirements are reviewed in accordance with HCFA's existing review process. Amendments, the assurances and related information described in §6002, and the additional assurance described in subsection C must be submitted to the HCFA regional office no later than April 1 of each year. HCFA reviews your submittal expeditiously and either approves the amendment or requests additional information from you. If additional information is requested, submit your response no later than July 1 to permit sufficient time for HCFA to review the response prior to the October 1 effective date. If the amendment is disapproved, you are required under the statute to submit a new amendment meeting the statute's requirements. The absence of approval does not relieve you of any obligation required under title XIX of the Act.

6003. HCFA ACTION

HCFA's acceptance of your assurances is based on its evaluation of the information submitted. HCFA evaluates assurances to determine whether you have made a finding to substantiate that the payment rates are reasonable and adequate and that the Medicare upper limit is not exceeded. HCFA also reviews your assurances that appropriate appeals procedures in compliance with the regulations are in effect, that you provide for uniform cost reporting and periodic audits, and that you have complied with the requirements for public notice. Additionally, with regard to inpatient hospital services, HCFA must be satisfied that you have made a finding that the methods and standards take into account hospitals which serve a disproportionate number of low income patients and also reduce the rate payable for inappropriate level of care services. HCFA must also be assured that recipients' rights to reasonable access to necessary services are not impeded as a result of implementation of the proposed rates.

HCFA's review is not for the purpose of accepting or validating your payment methods and standards from a technical standpoint. Nor does HCFA's approval of a State plan amendment indicate that HCFA believes that the payment methods and standards are the best means of establishing payment rates. Instead, HCFA's approval of a State plan amendment indicates that you have complied with the requirements in the statute and regulations.

6004. PUBLIC NOTICE

42 CFR 447.253(f) requires that you must provide a statement that you have complied with the public notice requirements in 42 CFR 447.205 for any significant proposed change in its methods and standards for setting payment rates for services. The notice must be published before the proposed effective date of the change and appear as a public announcement in one of the following publications:

- o A State register similar to the Federal Register.
- o The newspaper of widest circulation in each city with a population of 50,000 or more.
- o The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

Also, the notice must contain the following information:

- o A description of the proposed change in methods and standards, and information regarding how to obtain the data used (or to be used) in establishing the rates;
- o An estimate of an expected increase or decrease in annual aggregate expenditures;
- o An explanation of why the agency is changing its methods and standards;
- o Identification of a local agency in each county (such as a/the social services agency or health department) where copies of the proposed changes are available for public review;
- o An address where written comments may be sent and reviewed by the public; and
- o Information about the location, date and time of public hearings, if there are any.

6005. UPPER PAYMENT LIMIT REQUIREMENTS

42 CFR 447.253(b)(2) requires that the Medicaid agency find that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services or long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement. This revised upper limit requirement substantially reduces the administrative burden which was placed on the State by the upper limit requirement originally published on September 30, 1981 in 42 CFR 447.272. The regulations, redesignated in 42 CFR 447.253(b)(2), permit a State greater discretion in determining if the requirement has been met and emphasize the State's flexibility to develop procedures for applying the upper limit test. They relieve the State of the burden of having to use the detailed cost finding principles required by Medicare or of complying with a prescriptive formula approach in ascertaining what would have been paid for such services under the Medicare principles of reimbursement.

Implicit in the adoption of the Medicare principles in the upper payment limit in 42 CFR 447.253(b)(2) is the realization that the Medicare principles may be revised by statute or by regulation from time to time (e.g., changes in allowable cost definitions, cost allocation methods, etc.). 42 CFR 447.253(b)(2) is designed to accommodate all such changes without the need for periodic amendment of the Medicaid rules. For example, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248) amended title XVIII of the Social Security Act by adding a new section to limit Medicare payments for inpatient hospital services. In addition, the Social Security Amendments of 1983 (Public Law 98-21) provided for Medicare payment for inpatient hospital services under a prospective payment system (PPS), rather than a reasonable cost basis. These changes have implications for Medicaid because the regulations governing reimbursement for inpatient hospital services under Medicaid include a requirement that a State agency find that it does not pay more in the aggregate for these services than the amount that it estimates would be paid for the services under the Medicare principles of reimbursement.

Thus, in determining if you meet the test of the upper payment limit, your estimate must use the Medicare principles in effect at the time. Currently, the basic principles of this estimating process must also be consistent with

reimbursement limits set forth in 42 CFR 405.460, 42 CFR 405.463 and 42 CFR 405.470 which are as follows:

- o 42 CFR 405.460 sets forth a general principle that reimbursable provider costs not exceed the cost estimated to be necessary for the efficient delivery of needed health services. The regulation specifies a number of factors which are appropriate and practical to accomplish this, and implementing instructions spell out how we have decided to do this for a national health insurance program such as Medicare. Application of some of these procedures to a statewide program may require some modifications.

- o 42 CFR 405.463 sets forth other general principles regarding target rates and rates of increase control that are used in addition to the principles established under 42 CFR 405.460.

- o 42 CFR 405.470ff sets forth the specific provisions for implementing the prospective payment system and diagnosis related groups.

In determining whether you comply with the Medicare upper limit as required by 42 CFR 447.253(b)(2), you need not follow exactly every detailed procedure used to implement either of these principles in the Medicare program, so long as the principles are satisfied. However, where you have adopted wholly the Medicare principles and choose to depart from the Medicare procedures used to implement the principles, the State plans describe the nature of the variation in their reimbursement methodology, and, in any event, they indicate that the Medicare upper limit test is met.

To summarize, in determining whether the Medicare upper payment limitation is met, you are expected to do the following:

- o Consider the Medicare principles in 42 CFR 405.460;
- o Apply the rate of increase controls authorized in 42 CFR 405.463 for hospital services (as published annually in the Federal Register);
- o Consider Medicare payments under the prospective payment system;
- o Use an aggregate rather than facility-specific estimation; and
- o Make the determination a part of the required assurances. (See §6002.1.)

42 CFR 447.252 also requires that the State plan must specify if the agency chooses to apply the Medicare cost limits on an individual provider basis.

42 CFR 447.271, based on §1903(i)(3) of the Social Security Act, mandates additional cost limits on inpatient hospital services. Specifically, the regulation requires that the State agency not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for services. However, the State agency may pay a public provider furnishing services free or at a nominal charge at the same rate that is used if the provider's charges were equal to or greater than its costs.

6005.1 Other Policy Clarifications.--The responsibility of complying with the Medicaid upper payment limit requirements as explained herein, and documenting such compliance, rests with you. HCFA's oversight of your compliance is performed generally after the fact through an assessment, plan validation, or other audit type activity. (You are required, however, to assure that you have

made a finding whenever you make a significant change in the methods and standards, but not less often than annually, that your estimated Medicaid rates meet the payment limit requirements. HCFA reviews your findings as part of our current oversight activities.)

You do not need to consider and document the impact of the limits for all facilities in the State to support your finding of compliance with the requirement. That is, a random sample of facilities could be used for this purpose. Also, States with alternative systems are not precluded from making payments to individual facilities in excess of the limits. In this case, however, show your savings elsewhere in your payment system to ensure that the aggregate payout to all facilities did not exceed the limits.

You are no longer required to consider the impact of the former 223 routine cost limits for inpatient hospital services because the TEFRA limits and PPS supersede these earlier limits.

You possess the flexibility under the regulations to grant requested exemptions from or exceptions to the limits in a manner similar to that used by Medicare in 42 CFR 405.460.

Those States which adopt Medicare principles of reimbursement must amend the State plan if they choose not to make payments for the incentive and cost sharing amounts.

6006. APPEALS

42 CFR 447.253(c) requires that you must provide an appeals procedure in the plan that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as you determine appropriate. This requirement is in keeping with the intent of Congress to grant States more flexibility while retaining for providers an opportunity to avail themselves of an exception process when they believe an exception is warranted. The appeals procedure is a general requirement subject to the assurances required for approval under §1902(a)(13)(A) of the Act.

6300. PAYMENT FOR OUTPATIENT CLINICAL DIAGNOSTIC LABORATORY TESTS FOR CALENDAR QUARTERS BEGINNING ON OR AFTER OCTOBER 1, 1984.

6300.1. Introduction.--Pursuant to §2303 of the Deficit Reduction Act of 1984 for services rendered to Medicare beneficiaries on or after July 1, 1984, clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. These fee schedules have been established on the Medicare carrier's service area (not exceeding a statewide basis). The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires national limitation amounts to be applied to the Medicare payments for outpatient clinical diagnostic laboratory services.

For services rendered on or after July 1, 1986, the national limitation amount is 115 percent of the median of all the fee schedules established for a test for each laboratory setting (i.e., separately calculated for 60 and 62 percent fee schedules).

Effective with calendar quarters beginning on or after October 1, 1984 (for services rendered on or after July 1, 1984), Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. If a Medicare fee has not been established for a particular test reimbursed by Medicaid, no such limitation applies to the test. If a State agency has a buy-in arrangement with Part B of the Medicare program, it should ensure that the combined amounts of the Medicaid payment and the Medicare payment do not exceed the allowable Medicare fee or national limitation amount.

For services rendered on or after July 1, 1984, a nominal fee may be allowed under Medicare for separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. (See §6300.3.)

These guidelines are designed to provide assistance to the State Medicaid agencies in implementing, where applicable, the limitations of the Medicare fee schedules and the specimen collection fees into payment procedures. The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program. The establishment and use of (1) fee schedules for payment of clinical diagnostic laboratory tests and (2) nominal fees for specimen collection are discussed. The treatment of anatomic pathology services is provided. Reimbursement options available to States are also described.

6300.2. Fee Schedules for Outpatient Clinical Laboratory Tests.--Outpatient clinical diagnostic laboratory tests encompass tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests.

A. Application.--Each Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency. (See §6300.2.D.)

To determine the applicable fee schedule limitation for a test where more than one Medicare carrier operates within the State, the State agency may select one of the following options:

1. The lowest fee among the carriers within the State for this test. In this manner, the State may assure that its fee schedules for all tests are based upon the lowest Medicare fees within its State.

2. The average fee derived by combining the fee schedules of all Medicare carriers within the State.

3. The fee of the largest Medicare carrier within the State.

4. The fee of the Medicare carrier whose jurisdiction corresponds to the place of service.

B. Exceptions.--The fee schedule limitation applies to all clinical diagnostic laboratory tests, except:

1. laboratory tests furnished to an inpatient as part of a hospital or SNF benefit.

2. laboratory tests furnished to an inpatient of a hospital or SNF as part of a general diagnostic laboratory benefit and performed by the institution's laboratory.

3. laboratory tests that are included under the ESRD composite rate payment and that are furnished by hospital outpatient or free-standing ESRD dialysis facilities.

4. laboratory tests furnished by hospitals in Maryland and New Jersey. They have been granted waiver of Medicare reimbursement principles for outpatient services.

5. laboratory tests furnished to inpatients of a hospital with a waiver under §602(k) of the 1983 Amendments to the Social Security Act. This section of the Act provides that an outside supplier may bill under Part B for laboratory and other nonphysician services furnished to inpatients that would otherwise be reimbursed only through the hospital. Part B payment to the outside supplier for laboratory tests furnished to inpatients under the 602(k) waiver will be made at 80 percent of the reasonable charge if the claim is unassigned or at 100 percent of the reasonable charge if the claim is assigned. The fee schedule does apply to any tests furnished by the outside supplier to hospital outpatients and to nonhospital patients.

6. laboratory tests furnished to patients of rural health clinics under an all-inclusive rate.

7. laboratory tests provided by participating health maintenance organizations (HMO) or health care prepayment plans (HCPP) to an enrolled member of the plan.

8. laboratory tests furnished by a hospice.

C. Clinical Diagnostic Laboratory Services.--For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology Fourth Edition, 1986 printing, (CPT-4). Certain tests, however, are required to be performed by a physician and are therefore exempt from the fee schedule. These tests include:

80500-80502	Clinical pathology consultation
85095-85109	Codes dealing with bone marrow smears and biopsies
86077-86079	Blood bank services
88000-88125	Certain cytopathology services
88160-88199	Certain cytopathology services
88300-88399	Surgical pathology services

Some CPT-4 codes in the 80000 series are not clinical diagnostic laboratory tests. Such codes include codes for blood products such as whole blood, various red blood cell products, platelets, plasma and cryoprecipitates. Other codes for tests primarily associated with the provision of blood products are also not considered to be clinical diagnostic tests. These codes include the various blood crossmatching techniques.

The following codes are never subject to fee schedule limitations:

86012	86068
86013	86069
86016-86019	86072-86076
86024	86100
86026	86120
86028	86128
86034	86265-86267

The following codes should not be subject to fee schedule limitations when they are submitted for payment on the same bill with charges for blood products:

86011	86082
86014	86090
86031-86033	86095
86035	86096
86080	86105

If no blood product is provided and billed on the same claim, these codes are subject to the fee schedule.

Please note that for purposes of the fee schedule, clinical diagnostic laboratory tests include some services described as anatomic pathology services in CPT-4 (i.e., certain cervical, vaginal, or peripheral blood smears). Services excluded from the fee schedule when billed by an independent laboratory are reimbursable under existing reasonable charge rules and assignment may be taken on a case-by-case basis unless the laboratory enrolls as a participating supplier in which event assignment is mandatory. Where a service is performed by a physician for a hospital inpatient or outpatient and meets the definition of a physician laboratory service, the service is subject to the Medicare Economic Index and the freeze on physician fees under §2306 of the DRA of 1984. Physician laboratory services are anatomic pathology services, consultative pathology services, or services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient. Such service, however, when billed by an independent laboratory as a laboratory service for a nonhospital patient (e.g., surgical pathology) is not considered a physician service for purposes of the Medicare Economic Index or the physician fee freeze.

D. Calculation of Fee Schedule Amounts.--Beginning January 1, 1987, Medicare fee schedules will be updated on January 1 each year. The Medicare fee schedules (adjusted for any applicable national limitation amounts) will be furnished to the State Medicaid agency on magnetic tape by the Medicare carriers within the respective State. (See §6300.6 for tape formats.)

Carriers initially set the fee schedule amounts at 60 percent of the prevailing charges for laboratory tests performed in physicians' offices and by independent laboratories. For hospital outpatient laboratory tests, the fee schedule amount was established at 62 percent of the prevailing charges. Subsequent updates are made on the basis of changes in the Consumer Price Index.

Where a hospital laboratory acts as an independent laboratory; i.e., performs tests for persons who are nonhospital patients, the services are reimbursed using the 60 percent of prevailing charge fee schedule. A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. Where a tissue sample, blood sample, or specimen is taken by personnel that are not employed by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient.

The codes and terminology of the Health Care Common Procedure Coding System (HCPCS) are used to establish the fee schedule for Medicare. State Medicaid agencies which have not yet converted their coding systems to HCPCS should identify the equivalent tests in their own systems and use the fees of corresponding HCPCS codes for those tests in reviewing their current reimbursement levels.

6300.3. Fee Schedules for Specimen Collection.--Medicare will recognize separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. States are not required to recognize this fee. However, since specimen collection fees will be taken into account in determining whether a State paid more for a laboratory test than would be paid under Medicare, States must take into account Medicare policies in this area.

State agencies may consult with regional offices concerning the implementation of the fee schedule and specimen collection provisions.

Presently, Medicare will recognize up to \$3 for a specimen collection whether or not the specimens are referred to physicians or other laboratories for testing. This fee will not be paid to anyone who has not actually extracted the specimen from the patient. Only one collection fee may be allowed for each patient encounter, regardless of the number of specimens drawn. A specimen collection fee may be allowed only in circumstances including, but not limited to: (1) drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the sample is minimal, such as a throat culture or routine capillary puncture for clotting or bleeding time.

Medicare will recognize a specimen collection fee when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, i.e., venipuncture or urine sample by catheterization. A specimen collection fee should not be allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. A specimen collection fee not exceeding \$5 may be allowed in drawing a specimen from one patient in a nursing home or a homebound patient. An amount not exceeding \$3 per patient may be allowed when specimens are drawn from more than one patient during the same nursing home visit. Exceptions to the above rules may be permitted under certain circumstances, such as allowing a travel expense in addition to the specimen collection fee where the patient is confined to a nursing home in a distant rural area.

When independent (free-standing) or hospital-based ESRD facilities are paid on a composite rate basis, no specimen fees should be paid since specimen collection costs are included in the composite rate except for Method II home dialysis patients. Where the State permits reimbursement under Method II, a separate specimen collection fee may be paid if the specimen is drawn by an ESRD facility or laboratory. The specimen collection fee is not allowed when a physician or one of a physician's employees draws a specimen from a dialysis patient because it is included in the Monthly Capitation Payment.

6300.4 Who Can Bill and Receive Payment for Clinical Laboratory Tests.--Payment for clinical laboratory tests subject to the fee schedule may only be made to the person or entity performing or supervising the performance of the tests. The general rules of 42 CFR 447.10(g)(2), (3), and (4) on reassignment are followed for clinical diagnostic laboratory tests as for all other services.

6300.5 Competitive Bidding or Other Arrangements.--42 CFR 431.54(d) allows a Medicaid agency to enter into arrangements to purchase laboratory services. Section 1903(i)(7) of the Act requires that States may not pay more in the aggregate for clinical diagnostic laboratory tests than the amount that would be paid for the tests under Medicare fee schedule. If a Medicaid agency, therefore, enters into arrangements to purchase laboratory services, the total payment for the clinical diagnostic laboratory tests may not exceed the amount recognized by Medicare.

6300.6. Magnetic Tape File and Record Specifications for HCPCS Pricing Detail

HEADER TAPE SPECIFICATIONS

<u>Field No.</u>	<u>Field Name</u>	<u>Size</u>	<u>Picture</u>	<u>Field Specification</u>	<u>Remarks</u>
1	Label	5	X(5)	L	"HCPCS"
2	Filler	1	X		
3	Carrier #	5	9(5)	L	
4	Filler	1			
5	Interm. #	5	9(5)	L	
6	Filler	1			
7	Date Prevailing Updated	6	X(6)	L	MMDDYY
8	Filler	30			
9	Date File Created	6	X(6)	L	MMDDYY

<u>Name</u>	<u>Positions</u>	<u>Picture</u>
HCPCS	5	X(5)
60% Fee Schedule*	7	9(5)V99
62% Fee Schedule*	7	9(5)V99

DETAIL RECORD

<u>Field No.</u>	<u>Field Name</u>	<u>Size</u>	<u>Picture</u>	<u>Field Specification</u>
1	HCPCS	5	X(5)	L
2	Filler	2	XX	L
3	Filler	2	XX	L
4	60% Fee Schedule*	7	9(5)V99	R
5	62% Fee Schedule*	7	9(5)V99	R
6	Filler	10	X(10)	L
7	Carrier #	5	X(5)	L
8	Filler	2	XX	
9	Carrier Name	20	X(20)	L

*Adjusted for national limitation amounts.

6301. RURAL HEALTH CLINIC REIMBURSEMENT

Rural Health Clinics (RHC) are reimbursed an all-inclusive rate for services rendered. If nurse practitioners or physician assistants (as defined in 42 CFR 491.2) are not prohibited by State law from furnishing primary health care, a certified RHC will be reimbursed for services noted in 42 CFR 440.20(b) and (c).

RHC services, as defined in 42 CFR 440.20(b), and other ambulatory services furnished by a RHC as defined in 42 CFR 440.20(c) are reimbursed as follows:

A. Provider Clinics.--RHC services and other ambulatory services are reimbursed on a reasonable cost basis, based on Medicare cost reimbursement principles in 42 CFR Part 413. For purposes of this section, a provider clinic is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and licensed, governed, and supervised with other departments of the facility.

B. Freestanding Clinics That Do Not Offer Any Ambulatory Services Other Than RHC Services.-- Reimburse for RHC services at the reasonable cost rate per visit determined by the Medicare carrier.

C. Freestanding Clinics That Do offer Ambulatory Services Other Than RHC Services.-- Other ambulatory services are reimbursed by one of the following methods:

1. Ambulatory services and RHC services may be reimbursed at a single rate per visit that is based on the cost of all services furnished by the clinic. The rate must be determined by the Medicare carrier;

2. Other ambulatory services may be reimbursed at a rate set for each service by the State. The rate must not exceed the upper limits in 42 CFR Part 447, Subpart D. Reimburse RHC services at the Medicare reimbursement rate per visit, as determined by the Medicare carrier; or

3. Dental services may be reimbursed at a rate per visit that is based on the cost of dental services furnished by the clinic. Use a separate rate per visit using procedures applicable in determining the rate per visit for RHC services determined by the Medicare carrier. Ambulatory services other than dental services are reimbursed under C, 1 or 2.

D. Definition of Visit.-- For purposes of subsections C,1 and 3, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

6302. RURAL HEALTH CLINIC CARRIERS

The six intermediaries designated to act as carriers serving RHCs and the States are:

<u>Intermediaries</u>	<u>States</u>
Aetna Life Insurance Co. Petaluma, CA	Alaska, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota Missouri, Nevada, Nebraska, Ohio, Oregon, Samoa, Washington, Wisconsin
Associate Hospital Service of Maine d/b/a Maine Blue Cross & Blue Shield Portland, Maine	Maine
Blue Cross and Blue Shield of Tennessee Chattanooga, TN	Alabama, Florida, Georgia, Kentucky, Mississippi North Carolina, South Carolina, Tennessee
Blue Cross of Western PA Pittsburgh, PA	Connecticut, Delaware, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island Virginia, West Virginia
Rocky Mountain Hospital & Medical Service d/b/a Blue Cross and Blue Shield of Colorado Denver, CO	Arkansas, Colorado, Louisiana, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Texas Utah, Wyoming
New Hampshire - Vermont Health Service, Inc. Concord, NH	New Hampshire, Vermont

6303. FEDERALLY QUALIFIED HEALTH CENTER AND OTHER AMBULATORY
 SERVICES PAYMENT

Pay 100 percent of the costs which are reasonable and related to the cost of furnishing Federally Qualified Health Center (FQHC) services and other ambulatory services defined in §1905(a)(2)(C) of the Social Security Act. The State payment system may utilize prospectively determined payment rates or may pay interim rates subject to reconciliation at the end of a cost reporting period. Irrespective of the type of payment method utilized, the State must determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413. Other standards of reasonableness will be developed through regulation. Additional information will be provided when regulations are published in the Federal Register.

This is in accordance with §6404 of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, which amends §1902(a)(13)(E) of the Social Security Act.

6305. SPECIFIC UPPER LIMITS FOR MULTIPLE SOURCE AND "OTHER" DRUGS

In 1976, the Department of Health and Human Services (HHS) implemented drug reimbursement rules in 45 CFR Part 19 under the authority of statutes pertaining to upper payment limits for Medicaid and other programs. The authority to set an upper payment limit for services available under the Medicaid program is provided under §1902(a)(30)(A) of the Act.

HHS rules are intended to ensure that the Federal Government acts as a prudent buyer of drugs under Federal health programs. The rules set limits on payments for drugs supplied under Medicaid and other programs. Of the Federal programs involved, these rules have the greatest impact on the Medicaid program.

In 1983, an HHS task force was established to review the Department's drug reimbursement regulations in 45 CFR Part 19. Specific concerns presented to the task force, coupled with the Department's desire to take advantage of savings that are currently available in the marketplace for multiple source drugs, resulted in a revision of the regulations to change the procedures for drug payments. The final regulation was published on July 31, 1987 (52 Fed. Reg. 28648).

Section 4401 of OBRA 1990, added §1927 to the Act on reimbursement for prescription drugs under the Medicaid program which augments the upper limits established by current regulations at 42 CFR 447.301-333. Section 1927(f)(2) of the Act contains a provision that establishes new criteria for adding new drugs to the current FULs.

6305.1 Upper Limits Requirements.--

A. Multiple Source Drugs--

1. Definition.--A multiple source drug is a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

2. Establishment of Limit Under 42 CFR 447.332.--Under the authority of §1902(a)(30)(A) and the regulations in 42 CFR 447.332, HCFA establishes a specific upper limit for a multiple source drug if the following requirements are met:

- o All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the current edition of the publication, Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or successor publications); and

- o At least three suppliers list the drug in the current editions (or updates) of published compendia of cost information for drugs available for sale nationally (e.g., Red Book, Blue Book, Medi-Span.)

3. Application of New Limits Under §1927(f)(2).--Under the authority of §1927(f)(2), HCFA establishes listings that identify and set upper limits for multiple source drugs for which at least three of the formulations of the drug approved by the FDA have been evaluated as therapeutically and pharmaceutically equivalent (category A) in the most current edition of its publication Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or in successor publications) regardless of whether all additional formulations are rated as such.

4. Application of Limits Under 42 CFR 447.332 and §1927(f).--The agency's payment for multiple source drugs identified and listed in Addendum A must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee, (established by the State and specified in the State Plan), plus an amount based on the limit per unit which HCFA has determined to be equal to a 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs.

The upper limit for multiple source drugs for which a specific limit has been established does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. The handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription. A dual line prescription form does not satisfy the certification requirement. A checkoff box on a form is not acceptable, but, again a notification like "brand necessary" is allowable. For telephone prescriptions, decide what certification form and procedures are to be used. Providers may be allowed to keep the certification forms if the forms are available for inspection by their agency and HHS.

In accordance with current policy, Federal financial participation will not be provided for any drug on the FUL listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program and the drug has been found to be a less than effective or is identical, related or similar (IRS) to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid drug rebate program.

B. Other Drugs.--A drug described as an "other drug" is a brand name drug certified as medically necessary by a physician or a drug other than a multiple source drug (See §6305.1.A.). Payments for these drugs must not exceed, in the aggregate, payment levels determined by applying the lower of the:

- o Estimated acquisition costs, plus reasonable dispensing fees (established by the State and specified in the State Plan), or
- o The provider's usual and customary charges to the general public.

Estimated acquisition costs (EAC) means the agency's best estimate of the price generally, and currently, paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers. For example, in the past, many States based the EAC upon Average Wholesale Price (AWP) levels as contained in various commercially available publications. However, a number of studies have shown that in recent years the drug marketplace has changed and there is a preponderance of evidence that demonstrates that such AWP levels overstate the prices that pharmacists actually pay for drug products by as much as 10-20 percent because they do not reflect discounts, premiums, special offers or incentives, etc. Consequently, without valid documentation to the contrary, a published AWP level as a State determination of EAC without a significant discount being applied is not an acceptable estimate of prices generally and currently paid by providers.

6305.2 State Plan and Procedural Requirements.--

A. State Plan.--As required by 42 CFR 447.333(a), the State plan must comprehensively describe your payment methodology for prescription drugs.

B. Findings.--As required by 42 CFR 447.333(b), upon proposing significant State plan changes in payments for prescription drugs, and at least annually for multiple source drugs and triennially for all other drugs, make the following separate and distinct findings, which may not be aggregated for these purposes. The findings can be supported by any documented, acceptable method of sampling, imputation and statistical analysis used to make the determinations:

- o In the aggregate, Medicaid expenditures for multiple source drugs, identified in §6305.1.A. and listed in Addendum A, are in accordance with the upper limit requirements established by that section, and

- o In the aggregate, Medicaid expenditures for all "other drugs" are in accordance with the respective requirements noted in §6305.1.B.

C. Assurances.--42 CFR 447.333(b)(2) requires that, upon proposing significant State plan changes in payments for prescription drugs, and at least annually for multiple source drugs and triennially for other drugs, you must make assurances satisfactory to HCFA that the requirements in §6305.1 and §6305.2 are met. The acceptance of satisfactory assurances is the basis of approval of a State plan.

D. Recordkeeping.--As required by 42 CFR 447.333(c), maintain and make available to HCFA, upon request, data, mathematical or statistical computations, comparisons and any other pertinent records to support your findings and assurances.

E. Upper Limits and Federal Financial Participation (FFP).--In your assurance letter, indicate that you pay no more than the upper limits described in §6305.1, in accordance with 42 CFR 447.304(a). As required by 42 CFR 447.304(c), FFP is unavailable for payments for services that exceed the upper limits.

6305.3 Upper Limit Drug Price List Update For Multiple Source Drugs.--HCFA has developed a price listing of multiple source drugs to which the formula in §6305.1 applies. The listing of these drugs and any revisions to the list will be provided through Medicaid program issuances on a periodic basis (possibly, semi-annually). The effective date of the new prices will be subsequent to the issuance of each new listing and will be included in the issuance. The listing is in Addendum A.

6320. DIRECT REIMBURSEMENT BY STATES TO MEDICAID RECIPIENTS TO CORRECT ERRONEOUS DENIALS

This instruction implements and clarifies longstanding HCFA policy which makes direct reimbursement available to all individuals who pay for medical services between the date of an erroneous determination of ineligibility for Medicaid and the date that the determination is reversed.

6320.1 Background.--Some individuals, while appealing an initial denial of eligibility, incur and pay for covered Medicaid services. Subsequently, upon receipt of a favorable decision, the individuals request direct reimbursement from the State for services that would have been paid by Medicaid had the initial determination been correct.

The policy of direct reimbursement to recipients is an exception to the vendor payment principle in §1905(a) of the Act, which prohibits payments to recipients except in specific circumstances set forth in §1905(a) and in 42 CFR 447.25(d)(1). It was adopted in response to litigation on behalf of individuals who paid for covered medical services pending a reversal of an unfavorable determination. Section 1905(a) authorizes direct payment to recipients for certain physicians' services and dentists' services.

6320.2 Payment for Services.--States may make direct reimbursement to individuals who paid for covered services after an erroneous determination of ineligibility which is reversed on appeal. The purpose of this exception to the vendor payment principle is to correct the inequitable situation that results from an erroneous determination made by the agency.

6320.3 Requirements To Be Met Before Direct Reimbursement To Individuals Is Permitted.--FFP is available in State payments to individuals for direct reimbursement for corrective payment only if the following requirements are met:

- o The services were paid for during the period between a denial of eligibility and a successful appeal of that denial and the services were covered under the State plan at the time the services were provided.
- o Third party reimbursement is not available for the service.
- o Proof that payments were made by the applicant or a person legally responsible for the applicant's bills must be submitted. Direct payments must be supported by the provider's bills for service.
- o Vendor payments would otherwise have been appropriate except that the provider does not have to be participating.
- o Services must have been medically necessary when provided. However, because of your erroneous eligibility determination, the recipient was not subject to prior approval. Do not apply any prior approval requirements to such services.
- o Payment is made at the level of your fee schedule or the upper limit as specified in the State plan for the services in question, which was in effect at the time the service was provided, even though the individual may have paid more than that amount.

6400. PAYMENT FOR PHYSICIAN SERVICES TO PREGNANT WOMEN AND CHILDREN

6400.1 Introduction.--Effective January 1, 1992, §1903(i)(12) of the Act prohibits Medicaid payment for physician services provided to a child under the age of 21 or to a pregnant woman unless certain conditions are met. This applies to all physician services provided to a pregnant woman or to a child under 21, whether the service is pregnancy related or a service unique to children under 21. These physician qualifications also apply to any physician who provides prenatal care to presumptively eligible pregnant women.

6400.2 Physician Services to Children Under 21.--Federal financial participation (FFP) under Medicaid is not available for physician services provided to a child under 21 unless the physician provider meets at least one of the following criteria:

A. Is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in family practice or pediatrics by the American Osteopathic Association;

B. Is employed by or affiliated with a Federally qualified health center as defined in §1905(l)(2)(B) of the Act;

C. Holds admitting privileges at a hospital participating in an approved State Medicaid plan;

D. Is a member of the National Health Service Corps;

E. Documents a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in item A for purposes of specialized treatment and admission to a hospital;

F. Delivers such services in the emergency department of a hospital participating in the State plan approved under this title; or

G. Has been certified by the Secretary (or certified by the State in accordance with policies of the secretary) as qualified to provide physicians' services to a child under 21 years of age.

For the period January 1, 1992 through December 31, 1998, a physician who does not meet any of the specified criteria in items A through F but has a provider agreement with the State Medicaid agency may be considered certified under item G to receive reimbursement under Medicaid for services provided to a child under 21 years of age.

Effective January 1, 1999, a provider physician must meet at least one of the specified criteria listed in items A through F to receive reimbursement under Medicaid for physician services provided to a child under 21.

6400.3 Physician Services to Pregnant Women.--FFP under Medicaid is not available for physician services provided to a pregnant woman unless the physician provider meets at least one of the following criteria:

A. Is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics;

B. Is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association;

C. Is employed by or affiliated with a Federally qualified health center as defined in §1905(l)(2)(B) of the Act;

D. Holds admitting privileges at a hospital participating in an approved State Medicaid plan;

E. Is a member of the National Health Service Corps;

F. Documents a current, formal consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in items A or B for purposes of specialized treatment and admission to a hospital;

G. Delivers such services in the emergency department of a hospital participating in the State plan approved under this title; or

H. Has been certified by the Secretary (or certified by the State in accordance with policies of the Secretary) as qualified to provide physician services to pregnant women.

For the period January 1, 1992 through December 31, 1998, a physician who does not meet any of the specified criteria in items A through G but has a provider agreement with the State Medicaid agency may be considered certified under item H to receive reimbursement under Medicaid for services provided to a pregnant woman.

Effective January 1, 1999, a provider physician must meet at least one of the specified criteria listed in items A through G to receive reimbursement under Medicaid for physician services provided to a pregnant woman.

6400.4 Provider Agreements.--A provider agreement may list the specified criteria and direct the physician to indicate which criteria he or she meets. This establishes a record of physician providers who are eligible to receive payment from Medicaid for physician services provided to a pregnant woman or to a child under 21.

Addendum A--The following listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and §1927(e) of the Act, as amended by OBRA 1993. The development of the current Federal Upper Limit (FUL) listing has been accomplished by computer. Payments for multiple source drugs identified and listed in the accompanying addendum must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State plan), plus an amount based on the limit per unit which HCFA has determined to be equal to a 150 percent applied to the lowest price listed (in package sizes of 100 units, unless otherwise noted) in any of the published compendia of cost information of drugs. The listing is based on data current as of October 1996 from the First Data Bank (Blue Book), Medi-Span, and the Red Book. The revised Addendum A no longer references the commonly known brand names. However, the brand names are included in the FUL listing provided to the State agencies in electronic media format. The FUL price list is updated approximately every 6 months.

In accordance with current policy, Federal financial participation will not be provided for any drug on the FUL listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program and which has been found to be a less than effective or is identical, related, or similar (IRS) to the DESI drug. The DESI drug is identified by the Food and Drug Administration or reported by the drug manufacturer for purposes of the Medicaid drug rebate program.

The effective date of this list is January 1, 1997.

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Acebutolol Hydrochloride

Eq. 200 mg base, Capsule, Oral 100

Eq. 400 mg base, Capsule, Oral 100

0.2700 M

1.0988 B

Acetaminophen; Butalbital; Caffeine

325 mg; 50 mg; 40 mg, Capsule, Oral 100

325 mg; 50 mg; 40 mg, Tablet, Oral 100

0.1193 M

0.0450 M

Acetaminophen; Codeine Phosphate

300 mg; 15 mg, Tablet, Oral 100

300 mg; 30 mg, Tablet, Oral 100

300 mg; 60 mg, Tablet, Oral 100

0.0443 B

0.0675 B

0.1043 B

Acetaminophen; Hydrocodone Bitartrate

500 mg; 5 mg, Capsule, Oral 100

500 mg; 5 mg, Tablet, Oral 100

500 mg; 7.5 mg, Tablet, Oral 100

750 mg; 7.5 mg, Tablet, Oral 100

0.1763 B

0.0546 B

0.2453 B

0.2183 B

Acetaminophen; Oxycodone Hydrochloride

500 mg; 5 mg, Capsule, Oral 100

325 mg; 5 mg, Tablet, Oral 100

0.2993 B

0.1343 B

Acetaminophen; Propoxyphene Hydrochloride

650 mg; 65 mg, Tablet, Oral 100

0.1493 B

*B = BLUE BOOK M = MEDI-SPAN R = RED BOOK

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Acetaminophen; Propoxyphene Napsylate
650 mg; 100 mg, Tablet, Oral 100

\$0.0873 B

Acetazolamide
250 mg, Tablet, Oral 100

0.0938 B

Acetic Acid, Glacial
2%, Solution/Drops, Otic 15 ml

0.1250 B

Acetohexamide
250 mg, Tablet, Oral 100

0.2363 M

Albuterol Sulfate
Eq. 2 mg base/5 ml, Syrup, Oral 480 ml
Eq. 2 mg base, Tablet, Oral 100
Eq. 4 mg base, Tablet, Oral 100

0.0155 B

0.0323 B

0.0540 B

Allopurinol
100 mg, Tablet, Oral 100
300 mg, Tablet, Oral 100

0.0323 B

0.0743 B

Alprazolam
0.25 mg, Tablet, Oral 100
0.5 mg, Tablet, Oral 100
1 mg, Tablet, Oral 100
2 mg, Tablet, Oral 100

0.0503 B

0.0593 B

0.0810 B

0.2066 B

Amantadine Hydrochloride
100 mg, Capsule, Oral 100
50 mg/5 ml, Syrup, Oral 480 ml

0.1688 B

0.0656 M

Amiloride Hydrochloride; Hydrochlorothiazide
Eq. 5 mg Anhydrous; 50 mg, Tablet, Oral 100

0.0708 B

Aminophylline
100 mg, Tablet, Oral 100
200 mg, Tablet, Oral 100

0.0344 B

0.0539 B

Amitriptyline Hydrochloride
10 mg, Tablet, Oral 100
25 mg, Tablet, Oral 100
50 mg, Tablet, Oral 100
75 mg, Tablet, Oral 100
100 mg, Tablet, Oral 100
150 mg, Tablet, Oral 100

0.0173 B

0.0203 B

0.0278 B

0.0353 B

0.0428 B

0.0698 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Amitriptyline Hydrochloride; Chlordiazepoxide

Eq. 12.5 mg base; 5 mg, Tablet, Oral 100

\$0.1943 B

Eq. 25 mg base; 10 mg, Tablet, Oral 100

0.2588 B

Amitriptyline Hydrochloride; Perphenazine

10 mg; 2 mg, Tablet, Oral 100

0.0533 B

10 mg; 4 mg, Tablet, Oral 100

0.0623 B

25 mg; 2 mg, Tablet, Oral 100

0.0675 B

25 mg; 4 mg, Tablet, Oral 100

0.0813 B

50 mg; 4 mg, Tablet, Oral 100

0.1793 B

Amoxapine

25 mg, Tablet, Oral 100

0.4095 B

50 mg, Tablet, Oral 100

0.6323 B

100 mg, Tablet, Oral 100

1.1070 B

150 mg, Tablet, Oral 30

1.6850 B

Amoxicillin

250 mg, Capsule, Oral 100

0.0773 B

500 mg, Capsule, Oral 100

0.2294 B

125 mg/5 ml, Powder for reconstitution, Oral 80 ml

0.0281 B

125 mg/5 ml, Powder for reconstitution, Oral 100 ml

0.0173 B

125 mg/5 ml, Powder for reconstitution, Oral 150 ml

0.0129 B

250 mg/5 ml, Powder for reconstitution, Oral 80 ml

0.0540 B

250 mg/5 ml, Powder for reconstitution, Oral 100 ml

0.0255 B

250 mg/5 ml, Powder for reconstitution, Oral 150 ml

0.0185 B

Ampicillin/Ampicillin Trihydrate

Eq. 250 mg base, Capsule, Oral 100

0.0737 B

Eq. 500 mg base, Capsule, Oral 100

0.1343 B

Eq. 125 mg base/5 ml

Powder for reconstitution, Oral 100 ml

0.0225 M

Eq. 125 mg base/5 ml

Powder for reconstitution, Oral 200 ml

0.0176 B

Eq. 250 mg base/5 ml

Powder for reconstitution, Oral 100 ml

0.0315 M

Eq. 250 mg base/5 ml

Powder for reconstitution, Oral 200 ml

0.0255 B

Aspirin; Butalbital; Caffeine

325 mg; 50 mg; 40 mg, Capsule, Oral 100

0.3443 B

325 mg; 50 mg; 40 mg, Tablet, Oral 100

0.0390 M

Aspirin; Caffeine; Propoxyphene Hydrochloride

389 mg; 32.4 mg; 65 mg, Capsule, Oral 100

0.1689 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT-----
SOURCE *

Aspirin; Carisoprodol 325 mg; 200 mg, Tablet, Oral 100	\$0.5025 B
Aspirin; Methocarbamol 325 mg; 400 mg, Tablet, Oral 100	0.1515 B
Aspirin; Oxycodone Hydrochloride; Oxycodone Terephthalate 325 mg; 4.5 mg; 0.38 mg, Tablet, Oral 100	0.1763 B
Atenolol 25 mg, Tablet, Oral 100	0.0909 B
50 mg, Tablet, Oral 100	0.0464 B
100 mg, Tablet, Oral 100	0.0945 B
Atenolol; Chlorthalidone 50 mg; 25 mg, Tablet, Oral 100	0.5025 B
100 mg; 25 mg, Tablet, Oral 100	0.7275 B
Bacitracin Zinc; Neomycin Sulfate; Polymyxin B Sulfate 400 units/gm; Eq. 3.5 mg base/gm; 10,000 units/gm Ointment, Ophthalmic 3.5 gm	0.5571 M
Baclofen 10 mg, Tablet, Oral 100	0.1028 B
20 mg, Tablet, Oral 100	0.2010 B
Benzonatate 100 mg, Capsule, Oral 100	0.4860 B
Benztropine Mesylate 0.5 mg, Tablet, Oral 100	0.0240 B
1 mg, Tablet, Oral 100	0.0263 B
2 mg, Tablet, Oral 100	0.0330 B
Betamethasone Dipropionate Eq. 0.05% base, Cream, Topical 15 gm	0.2250 B
Eq. 0.05% base, Cream, Topical 45 gm	0.1517 B
Eq. 0.05% base, Lotion, Topical 20 ml	0.1598 B
Eq. 0.05% base, Lotion, Topical 60 ml	0.1595 B
Eq. 0.05% base, Ointment, Topical 15 gm	0.3750 B
Eq. 0.05% base, Ointment, Topical 45 gm	0.2153 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Betamethasone Valerate

Eq. 0.1% base, Cream, Topical 15 gm	\$0.1300 B
Eq. 0.1% base, Cream, Topical 45 gm	0.0733 B
Eq. 0.1% base, Lotion, Topical 60 ml	0.1112 B
Eq. 0.1% base, Ointment, Topical 15 gm	0.1650 B
Eq. 0.1% base, Ointment, Topical 45 gm	0.1163 B

Bethanechol Chloride

5 mg, Tablet, Oral 100	0.0210 B
10 mg, Tablet, Oral 100	0.0248 B
25 mg, Tablet, Oral 100	0.0345 B
50 mg, Tablet, Oral 100	0.0743 B

Bromodiphenhydramine Hydrochloride; Codeine Phosphate

12.5 mg/5 ml; 10 mg/5 ml, Syrup, Oral 480 ml	0.0186 B
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Brompheniramine Maleate; Codeine Phosphate;
Phenylpropanolamine Hydrochloride

2 mg/5 ml; 10 mg/5 ml; 12.5 mg/5 ml, Syrup, Oral 480 ml	0.0244 B
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Brompheniramine Maleate; Dextromethorphan Hydrobromide;
Pseudoephedrine Hydrochloride

2 mg/5 ml; 10 mg/5 ml; 30 mg/5 ml, Syrup, Oral 480 ml	0.0116 B
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Butabarbital Sodium

30 mg/5 ml, Elixir, Oral 480 ml	0.0135 B
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Captopril

12.5 mg, Tablet, Oral 100	0.0443 B
25 mg, Tablet, Oral 100	0.0666 B
50 mg, Tablet, Oral 100	0.1163 B
100 mg, Tablet, Oral 100	0.2082 B

Carbamazepine

200 mg, Tablet, Oral 100	0.1493 B
100 mg, Tablet, chewable, Oral 100	0.1467 B

Carbidopa; Levodopa

10 mg; 100 mg, Tablet, Oral 100	0.2828 B
25 mg; 100 mg, Tablet, Oral 100	0.3090 B
25 mg; 250 mg, Tablet, Oral 100	0.3699 B

Carisoprodol

350 mg, Tablet, Oral 100	0.0672 B
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GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Cefaclor

Eq. 250 mg base, Capsule, Oral 100	\$1.3312 B
Eq. 500 mg base, Capsule, Oral 100	2.7973 B
Eq. 125 mg base/5 ml	
Powder for reconstitution, Oral 75 ml	0.1990 B
Eq. 125 mg base/5 ml	
Powder for reconstitution, Oral 150 ml	0.1975 B
Eq. 250 mg base/5 ml	
Powder for reconstitution, Oral 75 ml	0.3790 B
Eq. 250 mg base/5 ml	
Powder for reconstitution, Oral 150 ml	0.3575 B
Eq. 375 mg base/5 ml	
Powder for reconstitution, Oral 50 ml	0.5685 B
Eq. 375 mg base/5 ml	
Powder for reconstitution, Oral 100 ml	0.5363 B

Cefadroxil/Cefadroxil Hemihydrate

Eq. 500 mg base, Capsule, Oral 100	2.7672 B
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Cephalexin

Eq. 250 mg base, Capsule, Oral 100	0.1103 B
Eq. 500 mg base, Capsule, Oral 100	0.2025 B
Eq. 125 mg base/5 ml	
Powder for reconstitution, Oral 100 ml	0.0308 B
Eq. 125 mg base/5 ml	
Powder for reconstitution, Oral 200 ml	0.0221 B
Eq. 250 mg base/5 ml	
Powder for reconstitution, Oral 100 ml	0.0443 B
Eq. 250 mg base/5 ml	
Powder for reconstitution, Oral 200 ml	0.0386 B
Eq. 250 mg base, Tablet, Oral 100	0.2999 B
Eq. 500 mg base, Tablet, Oral 100	0.6351 B

Cephradine

250 mg, Capsule, Oral 100	0.3281 B
500 mg, Capsule, Oral 100	0.6263 B
125 mg/5 ml, Powder for reconstitution, Oral 100 ml	0.0669 B
250 mg/5 ml, Powder for reconstitution, Oral 100 ml	0.1251 B

Chloramphenicol

0.5%, Solution/Drops, Ophthalmic 7.5 ml	0.4080 B
0.5%, Solution/Drops, Ophthalmic 15 ml	0.3240 B

Chlordiazepoxide Hydrochloride

5 mg, Capsule, Oral 100	0.0296 B
10 mg, Capsule, Oral 100	0.0315 B
25 mg, Capsule, Oral 100	0.0371 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Chlorothiazide

250 mg, Tablet, Oral 100

0.0498 M

500 mg, Tablet, Oral 100

0.0576 B

Chlorpheniramine Maleate

4 mg, Tablet, Oral 100

\$0.0103 B

Chlorpromazine Hydrochloride

100 mg base/ml, Concentrate, Oral 240

0.1257 M

Chlorpropamide

100 mg, Tablet, Oral 100

0.0306 B

250 mg, Tablet, Oral 100

0.0453 B

Chlorthalidone

25 mg, Tablet, Oral 100

0.0390 B

50 mg, Tablet, Oral 100

0.0434 B

Chlorthalidone; Clonidine Hydrochloride

15 mg; 0.1 mg, Tablet, Oral 100

0.2040 B

15 mg; 0.2 mg, Tablet, Oral 100

0.2625 B

15 mg; 0.3 mg, Tablet, Oral 100

0.3225 B

Chlorzoxazone

250 mg, Tablet, Oral 100

0.0528 B

500 mg, Tablet, Oral 100

0.0975 B

Cimetidine

200 mg, Tablet, Oral 100

0.1943 B

300 mg, Tablet, Oral 100

0.2093 B

400 mg, Tablet, Oral 100

0.3405 B

800 mg, Tablet, Oral 100

0.5993 B

Cimetidine Hydrochloride

Eq. 300 mg base/5 ml, Solution, Oral 480 ml

0.2322 B

Clemastine Fumarate

2.68 mg, Tablet, Oral 100

0.8213 B

Clindamycin Hydrochloride

Eq. 150 mg base, Capsule, Oral 100

0.7043 B

Clobetasol Propionate

0.05%, Cream, Topical 15 gm

1.4300 B

0.05%, Cream, Topical 30 gm

0.9895 B

0.05%, Cream, Topical 45 gm

0.9600 B

0.05%, Ointment, Topical 15 gm

1.4300 B

0.05%, Ointment, Topical 30 gm

0.9895 B

0.05%, Ointment, Topical 45 gm

0.9600 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Clonidine Hydrochloride

0.1 mg, Tablet, Oral 100

\$0.0240 B

0.2 mg, Tablet, Oral 100

0.0270 B

0.3 mg, Tablet, Oral 100

0.0338 B

Clorazepate Dipotassium

3.75 mg, Tablet, Oral 100

0.0375 B

7.5 mg, Tablet, Oral 100

0.0413 B

15 mg, Tablet, Oral 100

0.0480 B

Cloxacillin Sodium

Eq. 250 mg base, Capsule, Oral 100

0.2175 B

Eq. 500 mg base, Capsule, Oral 100

0.3893 B

Codeine Phosphate; Phenylephrine Hydrochloride;
Promethazine Hydrochloride

10 mg/5 ml; 5 mg/5 ml; 6.25 mg/5 ml, Syrup, Oral 480 ml

0.0130 B

Codeine Phosphate; Promethazine Hydrochloride

10 mg/5 ml; 6.25 mg/5 ml, Syrup, Oral 480 ml

0.0111 B

Codeine Phosphate; Pseudoephedrine Hydrochloride;
Triprolidine Hydrochloride

10 mg/5 ml; 30 mg/5 ml; 1.25 mg/5 ml, Syrup, Oral 480 ml

0.0103 B

Cyclobenzaprine Hydrochloride

10 mg, Tablet, Oral 100

0.1328 B

Cyclopentolate Hydrochloride

1%, Solution/Drops, Ophthalmic 15 ml

0.6500 B

Cyproheptadine Hydrochloride

2 mg/5 ml, Syrup, Oral 480 ml

0.0133 B

4 mg, Tablet, Oral 100

0.0174 B

Desipramine Hydrochloride

25 mg, Tablet, Oral 100

0.0714 B

50 mg, Tablet, Oral 100

0.1091 B

75 mg, Tablet, Oral 100

0.1242 B

100 mg, Tablet, Oral 100

0.4089 B

Desonide

0.05%, Cream, Topical 15 gm

0.6110 B

0.05%, Cream, Topical 60 gm

0.4178 B

Desoximetasone

0.05%, Cream, Topical 15 gm

0.5240 B

0.05%, Cream, Topical 60 gm

0.3370 B

0.25%, Cream, Topical 15 gm

0.6900 B

0.25%, Cream, Topical 60 gm

0.4118 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Dexamethasone 0.5 mg/5 ml, Elixir, Oral 100 ml	\$0.1118 M
Dexamethasone; Neomycin Sulfate; Polymyxin B Sulfate 0.1%; Eq. 3.5 mg base/gm; 10,000 units/gm Ointment, Ophthalmic 3.5 gm	1.2000 M
Dexamethasone Sodium Phosphate Eq. 0.05% Phosphate, Ointment, Ophthalmic 3.5 gm	0.9600 B
Eq. 0.1% Phosphate, Solution/Drops, Ophthalmic 5 ml	0.7140 B
Dexamethasone Sodium Phosphate; Neomycin Sulfate Eq. 0.1% Phosphate; Eq. 3.5 mg base/ml Solution/Drops, Ophthalmic 5 ml	1.3500 B
Dextromethorphan Hydrobromide; Promethazine Hydrochloride 15 mg/5 ml; 6.25 mg/5 ml, Syrup, Oral 480 ml	0.0109 B
Diazepam 2 mg, Tablet, Oral 100	0.0209 B
5 mg, Tablet, Oral 100	0.0221 B
10 mg, Tablet, Oral 100	0.0246 B
Diclofenac Sodium 25 mg, Tablet, Delayed Release, Oral 100	0.5163 B
50 mg, Tablet, Delayed Release, Oral 100	0.8544 B
75 mg, Tablet, Delayed Release, Oral 100	0.9647 B
Dicloxacillin Sodium Eq. 250 mg base, Capsule, Oral 100	0.1943 B
Eq. 500 mg base, Capsule, Oral 100	0.3743 B
Diethylpropion Hydrochloride 25 mg, Tablet, Oral 100	0.0537 B
Diltiazem Hydrochloride 60 mg, Capsule, extended release, Oral 100	0.7740 B
90 mg, Capsule, extended release, Oral 100	0.8498 B
30 mg, Tablet, Oral 100	0.1085 B
60 mg, Tablet, Oral 100	0.1689 B
90 mg, Tablet, Oral 100	0.2309 B
120 mg, Tablet, Oral 100	0.3020 B
Diphenhydramine Hydrochloride 25 mg, Capsule, Oral 100	0.0169 B
50 mg, Capsule, Oral 100	0.0206 B
12.5 mg/5 ml, Elixir, Oral 480 ml	0.0061 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Dipivefrin Hydrochloride

0.1%, Solution/Drops, Ophthalmic 5 ml

\$2.1900 M

0.1%, Solution/Drops, Ophthalmic 10 ml

2.0250 B

0.1%, Solution/Drops, Ophthalmic 15 ml

1.9950 B

Dipyridamole

25 mg, Tablet, Oral 100

0.0270 B

50 mg, Tablet, Oral 100

0.0413 B

75 mg, Tablet, Oral 100

0.0593 B

Disopyramide Phosphate

Eq. 100 mg base, Capsule, Oral 100

0.1043 B

Eq. 150 mg base, Capsule, Oral 100

0.1193 B

Doxepin Hydrochloride

Eq. 10 mg base, Capsule, Oral 100

0.0398 B

Eq. 25 mg base, Capsule, Oral 100

0.0443 B

Eq. 50 mg base, Capsule, Oral 100

0.0660 B

Eq. 75 mg base, Capsule, Oral 100

0.0893 B

Eq. 100 mg base, Capsule, Oral 100

0.1125 B

Eq. 150 mg base, Capsule, Oral 100

0.2993 B

Eq. 10 mg base/ml, Concentrate, Oral 120 ml

0.1362 B

Doxycycline Hyclate

Eq. 100 mg base, Capsule, Oral 50

0.1125 B

Eq. 100 mg base, Capsule, Coated Pellets, Oral 50

1.8585 B

Eq. 100 mg base, Tablet, Oral 50

0.1125 B

Ergocalciferol

50,000 iu, Capsule, Oral 100

0.0578 B

Ergoloid Mesylates

1 mg, Tablet, Oral 100

0.1388 B

1 mg, Tablet, Sublingual 100

0.0957 B

Erythromycin

250 mg, Capsule, Delayed Release Pellets, Oral 100

0.1913 B

2%, Gel, Topical 30 gm

0.5245 B

2%, Gel, Topical 60 gm

0.4997 B

0.5%, Ointment, Ophthalmic 3.5 gm

1.2171 B

2%, Solution, Topical 60 ml

0.0650 B

333 mg, Tablet, Delayed Release, Oral 100

0.3449 B

Erythromycin Estolate

Eq. 250 mg base, Capsule, Oral 100

0.2292 B

Eq. 125 mg base/5 ml, Suspension, Oral 480 ml

0.0512 B

Eq. 250 mg base/5 ml, Suspension, Oral 480 ml

0.0858 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT-----
SOURCE *

Erythromycin Ethylsuccinate

Eq. 200 mg base/5 ml, Granule, Oral 100 ml	\$0.0824 B
Eq. 200 mg base/5 ml, Granule, Oral 200 ml	0.0782 B
Eq. 200 mg base/5 ml, Suspension, Oral 200 ml	0.0697 M
Eq. 200 mg base/5 ml, Suspension, Oral 480 ml	0.0248 B
Eq. 400 mg base/5 ml, Suspension, Oral 480 ml	0.0436 B
Eq. 400 mg base, Tablet, Oral 100	0.2243 B

Erythromycin Ethylsuccinate; Sulfisoxazole Acetyl

Eq. 200 mg base/5 ml; Eq. 600 mg base/5 ml Granule, Oral 100 ml	0.0893 B
Eq. 200 mg base/5 ml; Eq. 600 mg base/5 ml Granule, Oral 150 ml	0.0850 B
Eq. 200 mg base/5 ml; Eq. 600 mg base/5 ml Granule, Oral 200 ml	0.0824 B

Erythromycin Stearate

Eq. 250 mg base, Tablet, Oral 100	0.1425 M
Eq. 500 mg base, Tablet, Oral 100	0.2325 B

Estropipate

3 mg, Tablet, Oral 100	1.0940 B
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Ethinyl Estradiol; Norethindrone

0.035 mg; 0.5 mg, Tablet, Oral-21 21	1.0743 M
0.035 mg; 1 mg, Tablet, Oral-21 21	0.5367 B
0.035 mg; 0.5 mg, Tablet, Oral-28 28	0.4025 B
0.035 mg; 1 mg, Tablet, Oral-28 28	0.3828 B

Fenoprofen Calcium

Eq. 600 mg base, Tablet, Oral 100	0.1898 B
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Fluocinolone Acetonide

0.01%, Cream, Topical 15 gm	0.0840 B
0.01%, Cream, Topical 60 gm	0.0413 B
0.025%, Cream, Topical 15 gm	0.1050 B
0.025%, Cream, Topical 60 gm	0.0612 B
0.025%, Ointment, Topical 15 gm	0.1910 B
0.025%, Ointment, Topical 60 gm	0.0968 B
0.01%, Solution, Topical 20 ml	0.1763 B
0.01%, Solution, Topical 60 ml	0.0938 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Fluocinonide

0.05%, Cream, Topical 15 gm	\$0.2350 B
0.05%, Cream, Topical 30 gm	0.1825 B
0.05%, Cream, Topical 60 gm	0.1625 B
0.05%, Cream, Topical 120 gm	0.1963 B
0.05%, Gel, Topical 60 gm	0.5978 B
0.05%, Ointment, Topical 15 gm	1.1480 B
0.05%, Ointment, Topical 30 gm	0.8425 B
0.05%, Ointment, Topical 60 gm	0.6680 B
0.05%, Solution, Topical 60 ml	0.2738 B

Fluphenazine Hydrochloride

1 mg, Tablet, Oral 100	0.2243 B
2.5 mg, Tablet, Oral 100	0.3338 B
5 mg, Tablet, Oral 100	0.4163 B
10 mg, Tablet, Oral 100	0.5025 B

Flurazepam Hydrochloride

15 mg, Capsule, Oral 100	0.0525 B
30 mg, Capsule, Oral 100	0.0675 B

Flurbiprofen

50 mg, Tablet, Oral 100	0.6627 B
100 mg, Tablet, Oral 100	0.5678 B

Folic Acid

1 mg, Tablet, Oral 100	0.0338 B
1 mg, Tablet, Oral 1000	0.0089 B

Furosemide

20 mg, Tablet, Oral 100	0.0210 M
40 mg, Tablet, Oral 100	0.0254 B
80 mg, Tablet, Oral 100	0.0563 B

Gemfibrozil

600 mg, Tablet, Oral 60	0.1800 B
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Gentamicin Sulfate

Eq. 0.1% base, Cream, Topical 15 gm	0.1350 B
Eq. 0.3% base, Ointment, Ophthalmic 3.5 gm	3.8571 B
Eq. 0.1% base, Ointment, Topical 15 gm	0.1350 B
Eq. 0.1% base, Ointment, Topical 30 gm	0.1405 B
Eq. 0.3% base, Solution/Drops, Ophthalmic 5 ml	0.5040 M
Eq. 0.3% base, Solution/Drops, Ophthalmic 15 ml	0.4150 B

Glipizide

5 mg, Tablet, Oral 100	0.0653 B
10 mg, Tablet, Oral 100	0.1163 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Gramicidin; Neomycin Sulfate; Polymyxin B Sulfate

0.025 mg/ml; Eq. 1.75 mg base/ml; 10,000 units/ml

Solution/Drops, Ophthalmic 10 ml

\$0.5025 B

Griseofulvin, Ultramicrocrystalline

125 mg, Tablet, Oral 100

0.3893 B

165 mg, Tablet, Oral 100

0.6750 M

250 mg, Tablet, Oral 100

0.7493 B

330 mg, Tablet, Oral 100

0.6743 B

Guanabenz Acetate

Eq. 4 mg base, Tablet, Oral 100

0.5063 B

Eq. 8 mg base, Tablet, Oral 100

0.7575 B

Haloperidol

0.5 mg, Tablet, Oral 100

0.0188 B

1 mg, Tablet, Oral 100

0.0210 B

2 mg, Tablet, Oral 100

0.0203 B

5 mg, Tablet, Oral 100

0.0293 B

10 mg, Tablet, Oral 100

0.0405 B

20 mg, Tablet, Oral 100

0.1200 B

Haloperidol Lactate

Eq. 2 mg base/ml, Concentrate, Oral 15 ml

0.5290 B

Eq. 2 mg base/ml, Concentrate, Oral 120 ml

0.1313 B

Homatropine Methylbromide; Hydrocodone Bitartrate

1.5 mg/5 ml; 5 mg/5 ml, Syrup, Oral 480 ml

0.0186 B

Hydralazine Hydrochloride

10 mg, Tablet, Oral 100

0.0188 B

25 mg, Tablet, Oral 100

0.0188 B

50 mg, Tablet, Oral 100

0.0263 B

100 mg, Tablet, Oral 100

0.0428 B

Hydralazine Hydrochloride; Hydrochlorothiazide

25 mg; 25 mg, Capsule, Oral 100

0.0788 B

50 mg; 50 mg, Capsule, Oral 100

0.0915 B

100 mg; 50 mg, Capsule, Oral 100

0.1928 B

Hydrochlorothiazide

25 mg, Tablet, Oral 100

0.0168 B

50 mg, Tablet, Oral 100

0.0231 B

100 mg, Tablet, Oral 100

0.0480 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT-----
SOURCE *

Hydrochlorothiazide; Methyldopa

15 mg; 250 mg, Tablet, Oral 100

\$0.1043 B

25 mg; 250 mg, Tablet, Oral 100

0.1043 B

30 mg; 500 mg, Tablet, Oral 100

0.5766 M

50 mg; 500 mg, Tablet, Oral 100

0.5919 M

Hydrochlorothiazide; Propranolol Hydrochloride

25 mg; 40 mg, Tablet, Oral 100

0.0606 B

25 mg; 80 mg, Tablet, Oral 100

0.0906 B

Hydrochlorothiazide; Spironolactone

25 mg; 25 mg, Tablet, Oral 100

0.0533 B

Hydrochlorothiazide; Triamterene

25 mg; 50 mg, Capsule, Oral 100

0.1770 B

25 mg; 37.5 mg, Tablet, Oral 100

0.3075 M

50 mg; 75 mg, Tablet, Oral 100

0.0533 M

Hydrocortisone

0.5%, Cream, Topical 15 gm

0.1140 B

0.5%, Cream, Topical 30 gm

0.0400 M

0.5%, Cream, Topical 120 gm

0.0405 B

0.5%, Cream, Topical 454 gm

0.0293 B

1%, Cream, Topical 30 gm

0.0645 M

2.5%, Cream, Topical 20 gm

0.2063 B

2.5%, Cream, Topical 30 gm

0.1550 B

2.5%, Cream, Topical 454 gm

0.1873 M

0.5%, Lotion, Topical 60 ml

0.0398 B

0.5%, Lotion, Topical 120 ml

0.0400 B

1%, Lotion, Topical 60 ml

0.0725 M

1%, Lotion, Topical 120 ml

0.0506 M

2.5%, Lotion, Topical 60 ml

0.2875 M

1%, Ointment, Topical 30 gm

0.0645 B

2.5%, Ointment, Topical 20 gm

0.2738 B

Hydroxychloroquine Sulfate

200 mg, Tablet, Oral 100

1.0800 B

Hydroxyzine Hydrochloride

10 mg/5 ml, Syrup, Oral 480 ml

0.0141 M

10 mg, Tablet, Oral 100

0.0221 B

25 mg, Tablet, Oral 100

0.0345 B

50 mg, Tablet, Oral 100

0.0398 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Hydroxyzine Pamoate

Eq. 25 mg hcl, Capsule, Oral 100

\$0.0833 B

Eq. 50 mg hcl, Capsule, Oral 100

0.1028 B

Eq. 100 mg hcl, Capsule, Oral 100

0.2243 B

Ibuprofen

400 mg, Tablet, Oral 100

0.0338 B

600 mg, Tablet, Oral 100

0.0443 B

800 mg, Tablet, Oral 100

0.0615 B

Imipramine Hydrochloride

10 mg, Tablet, Oral 100

0.0188 B

25 mg, Tablet, Oral 100

0.0233 B

50 mg, Tablet, Oral 100

0.0308 B

Indomethacin

25 mg, Capsule, Oral 100

0.0323 B

50 mg, Capsule, Oral 100

0.0488 B

75 mg, Capsule, extended release, Oral 100

0.5093 B

Isoniazid

100 mg, Tablet, Oral 100

0.0263 B

300 mg, Tablet, Oral 100

0.0525 B

Isosorbide Dinitrate

5 mg, Tablet, Oral 100

0.0210 B

10 mg, Tablet, Oral 100

0.0206 B

20 mg, Tablet, Oral 100

0.0218 B

30 mg, Tablet, Oral 100

0.0293 B

2.5 mg, Tablet, Sublingual 100

0.0368 B

5 mg, Tablet, Sublingual 100

0.0353 B

Lactulose

10 gm/15 ml, Solution, Oral 480 ml

0.0259 B

Leucovorin Calcium

Eq. 5 mg base, Tablet, Oral 100

2.0993 B

Lidocaine Hydrochloride

2%, Solution, Oral 100 ml

0.0315 B

Lindane

1%, Lotion, Topical 60 ml

0.0435 B

1%, Lotion, Topical 480 ml

0.0248 B

1%, Shampoo, Topical 60 ml

0.0482 B

1%, Shampoo, Topical 480 ml

0.0280 B

Lithium Carbonate

300 mg, Capsule, Oral 100

0.0525 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Lithium Citrate

Eq. 300 mg Carbonate/5 ml, Syrup, Oral 480 ml

\$0.0280 B

Loperamide Hydrochloride

2 mg, Capsule, Oral 100

0.2475 B

Lorazepam

0.5 mg, Tablet, Oral 100

0.0173 B

1 mg, Tablet, Oral 100

0.0207 B

2 mg, Tablet, Oral 100

0.0228 B

Loxapine Succinate

Eq. 5 mg base, Capsule, Oral 100

0.4620 M

Eq. 10 mg base, Capsule, Oral 100

0.6353 M

Eq. 25 mg base, Capsule, Oral 100

0.8993 B

Eq. 50 mg base, Capsule, Oral 100

1.2113 M

Maprotiline Hydrochloride

25 mg, Tablet, Oral 100

0.1943 B

50 mg, Tablet, Oral 100

0.2910 B

75 mg, Tablet, Oral 100

0.4088 B

Meclizine Hydrochloride

12.5 mg, Tablet, Oral 100

0.0270 B

25 mg, Tablet, Oral 100

0.0338 B

25 mg, Tablet, chewable, Oral 100

0.0254 B

Meclofenamate Sodium

Eq. 50 mg base, Capsule, Oral 100

0.1583 B

Eq. 100 mg base, Capsule, Oral 100

0.2393 B

Megestrol Acetate

20 mg, Tablet, Oral 100

0.4463 B

40 mg, Tablet, Oral 100

0.7793 B

Meprobamate

200 mg, Tablet, Oral 100

0.0398 B

400 mg, Tablet, Oral 100

0.0480 B

Mestranol; Norethindrone

0.05 mg; 1 mg, Tablet, Oral-21 21

0.5367 B

0.05 mg; 1 mg, Tablet, Oral-28 28

0.3828 B

Metaproterenol Sulfate

10 mg/5 ml, Syrup, Oral 480 ml

0.0141 B

10 mg, Tablet, Oral 100

0.0743 B

20 mg, Tablet, Oral 100

0.1328 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT-----
SOURCE *

Methazolamide

25 mg, Tablet, Oral 100

\$0.3563 B

50 mg, Tablet, Oral 100

0.5138 B

Methocarbamol

500 mg, Tablet, Oral 100

0.0675 B

750 mg, Tablet, Oral 100

0.0893 B

Methotrexate Sodium

Eq. 2.5 mg base, Tablet, Oral 100

1.7993 B

Methyclothiazide

2.5 mg, Tablet, Oral 100

0.0872 B

5 mg, Tablet, Oral 100

0.0531 B

Methyldopa

125 mg, Tablet, Oral 100

0.0615 M

250 mg, Tablet, Oral 100

0.0675 B

500 mg, Tablet, Oral 100

0.1215 B

Methylphenidate Hydrochloride

5 mg, Tablet, Oral 100

0.3329 B

10 mg, Tablet, Oral 100

0.4635 B

20 mg, Tablet, Oral 100

0.6743 B

20 mg, Tablet, extended release, Oral 100

1.1025 B

Metoclopramide Hydrochloride

Eq. 5 mg base, Tablet, Oral 100

0.1643 B

Eq. 10 mg base, Tablet, Oral 100

0.0188 B

Metoprolol Tartrate

50 mg, Tablet, Oral 100

0.0825 B

100 mg, Tablet, Oral 100

0.1185 B

Metronidazole

250 mg, Tablet, Oral 100

0.0330 B

500 mg, Tablet, Oral 100

0.0683 B

Minocycline Hydrochloride

Eq. 50 mg base, Capsule, Oral 100

0.4928 B

Minoxidil

2.5 mg, Tablet, Oral 100

0.1200 B

10 mg, Tablet, Oral 100

0.1575 B

Naphazoline Hydrochloride

0.1%, Solution/Drops, Ophthalmic 15 ml

0.3150 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Naproxen

250 mg, Tablet, Oral 100

\$0.1103 B

375 mg, Tablet, Oral 100

0.1517 B

500 mg, Tablet, Oral 100

0.1823 B

Naproxen Sodium

Eq. 250 mg base, Tablet, Oral 100

0.1470 B

Eq. 500 mg base, Tablet, Oral 100

0.2288 B

Niacin

500 mg, Tablet, Oral 100

0.0299 M

Nifedipine

10 mg, Capsule, Oral 100

0.0881 B

20 mg, Capsule, Oral 100

0.1748 B

Nitrofurantoin, Macrocrystalline

50 mg, Capsule, Oral 100

0.5957 B

100 mg, Capsule, Oral 100

1.0122 B

Nitrofurazone

0.2%, Ointment, Topical 454 gm

0.0167 B

Nortriptyline Hydrochloride

Eq. 10 mg base, Capsule, Oral 100

0.1155 M

Eq. 25 mg base, Capsule, Oral 100

0.1590 M

Eq. 50 mg base, Capsule, Oral 100

0.1943 M

Eq. 75 mg base, Capsule, Oral 100

0.2483 M

Nystatin

100,000 units/gm, Cream, Topical 15 gm

0.0970 B

100,000 units/gm, Cream, Topical 30 gm

0.0725 B

100,000 units/gm, Ointment, Topical 15 gm

0.0970 B

100,000 units/gm, Ointment, Topical 30 gm

0.1200 B

100,000 units/ml, Suspension, Oral 60 ml

0.0520 B

100,000 units/ml, Suspension, Oral 480 ml

0.0383 B

500,000 units, Tablet, Oral 100

0.1193 B

100,000 units, Tablet, Vaginal 15

0.7310 B

100,000 units, Tablet, Vaginal 30

0.6625 B

Nystatin; Triamcinolone Acetonide

100,000 units/gm; 0.1%, Cream, Topical 15 gm

0.1250 B

100,000 units/gm; 0.1%, Cream, Topical 30 gm

0.1050 B

100,000 units/gm; 0.1%, Cream, Topical 60 gm

0.0788 B

100,000 units/gm; 0.1%, Cream, Topical 120 gm

0.1116 B

100,000 units/gm; 0.1%, Ointment, Topical 15 gm

0.1150 B

100,000 units/gm; 0.1%, Ointment, Topical 30 gm

0.0975 B

100,000 units/gm; 0.1%, Ointment, Topical 60 gm

0.0800 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Oxacillin Sodium

Eq. 250 mg base, Capsule, Oral 100

\$0.2175 B

Eq. 500 mg base, Capsule, Oral 100

0.4193 B

Eq. 250 mg base/5 ml

Powder for reconstitution, Oral 100 ml

0.0525 B

Oxazepam

10 mg, Capsule, Oral 100

0.0563 B

15 mg, Capsule, Oral 100

0.0705 B

30 mg, Capsule, Oral 100

0.0915 B

Oxybutynin Chloride

5 mg, Tablet, Oral 100

0.1784 B

Penicillin V Potassium

Eq. 125 mg base/5 ml

Powder for reconstitution, Oral 100 ml

0.0165 B

Eq. 125 mg base/5 ml

Powder for reconstitution, Oral 200 ml

0.0112 B

Eq. 250 mg base/5 ml

Powder for reconstitution, Oral 100 ml

0.0188 B

Eq. 250 mg base/5 ml

Powder for reconstitution, Oral 200 ml

0.0154 B

Eq. 250 mg base, Tablet, Oral 100

0.0522 B

Eq. 500 mg base, Tablet, Oral 100

0.0818 B

Perphenazine

2 mg, Tablet, Oral 100

0.2993 B

4 mg, Tablet, Oral 100

0.4103 B

8 mg, Tablet, Oral 100

0.4965 B

16 mg, Tablet, Oral 100

0.6713 B

Phendimetrazine Tartrate

35 mg, Tablet, Oral 100

0.0750 M

Phentermine Hydrochloride

30 mg, Capsule, Oral 100

0.0443 B

37.5 mg, Capsule, Oral 100

0.1403 M

37.5 mg, Tablet, Oral 100

0.1208 B

Phenylephrine Hydrochloride; Promethazine Hydrochloride

5 mg/5 ml; 6.25 mg/5 ml, Syrup, Oral 480 ml

0.0081 B

Pindolol

5 mg, Tablet, Oral 100

0.2325 B

10 mg, Tablet, Oral 100

0.3375 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Piroxicam

10 mg, Capsule, Oral 100

\$0.1125 B

20 mg, Capsule, Oral 100

0.1403 B

Potassium Chloride

8 meq., Tablet, extended release, Oral 100

0.0735 B

Prazosin Hydrochloride

Eq. 1 mg base, Capsule, Oral 100

0.0624 B

Eq. 2 mg base, Capsule, Oral 100

0.0720 B

Eq. 5 mg base, Capsule, Oral 100

0.1193 B

Prednisolone Sodium Phosphate

Eq. 0.9% Phosphate, Solution/Drops, Ophthalmic 5 ml

1.0200 B

Eq. 0.9% Phosphate, Solution/Drops, Ophthalmic 10 ml

1.0875 M

Eq. 0.9% Phosphate, Solution/Drops, Ophthalmic 15 ml

0.3750 B

Eq. 0.11% Phosphate, Solution/Drops, Ophthalmic 5 ml

1.5000 M

Prednisolone Sodium Phosphate; Sulfacetamide Sodium

Eq. 0.23% Phosphate; 10%,
Solution/Drops, Ophthalmic 5 ml

2.3250 B

Eq. 0.23% Phosphate; 10%
Solution/Drops, Ophthalmic 10 ml

1.5525 B

Prednisone

1 mg, Tablet, Oral 100

0.0339 M

5 mg, Tablet, Oral 100

0.0263 B

10 mg, Tablet, Oral 100

0.0488 B

20 mg, Tablet, Oral 100

0.0743 B

50 mg, Tablet, Oral 100

0.1998 M

Primidone

250 mg, Tablet, Oral 100

0.3030 B

Probenecid

500 mg, Tablet, Oral 100

0.1154 B

Procainamide Hydrochloride

250 mg, Capsule, Oral 100

0.0683 B

375 mg, Capsule, Oral 100

0.0743 B

500 mg, Capsule, Oral 100

0.0848 B

250 mg, Tablet, extended release, Oral 100

0.1640 B

500 mg, Tablet, extended release, Oral 100

0.1553 B

750 mg, Tablet, extended release, Oral 100

0.2438 B

Promethazine Hydrochloride

6.25 mg/5 ml, Syrup, Oral 480 ml

0.0070 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT-----
SOURCE *

Propantheline Bromide

15 mg, Tablet, Oral 100

\$0.2222 B

Propoxyphene Hydrochloride

65 mg, Capsule, Oral 100

0.0488 B

Propranolol Hydrochloride

60 mg, Capsule, extended release, Oral 100

0.5340 B

80 mg, Capsule, extended release, Oral 100

0.6375 B

120 mg, Capsule, extended release, Oral 100

0.8025 B

160 mg, Capsule, extended release, Oral 100

1.0673 B

10 mg, Tablet, Oral 100

0.0143 B

20 mg, Tablet, Oral 100

0.0165 B

40 mg, Tablet, Oral 100

0.0204 B

60 mg, Tablet, Oral 100

0.0255 B

80 mg, Tablet, Oral 100

0.0263 B

Pseudoephedrine Hydrochloride; Triprolidine Hydrochloride

30 mg/5 ml; 1.25 mg/5 ml, Syrup, Oral 480 ml

0.0074 M

60 mg; 2.5 mg, Tablet, Oral 100

0.0291 B

Quinidine Gluconate

324 mg, Tablet, extended release, Oral 100

0.1725 B

Quinidine Sulfate

200 mg, Tablet, Oral 100

0.0962 B

300 mg, Tablet, Oral 100

0.1493 B

Selenium Sulfide

2.5%, Lotion/Shampoo, Topical 120 ml

0.0325 B

Silver Sulfadiazine

1%, Cream, Topical 20 gm

0.1695 B

1%, Cream, Topical 50 gm

0.1110 B

1%, Cream, Topical 85 gm

0.1168 B

1%, Cream, Topical 400 gm

0.0635 B

1%, Cream, Topical 1000 gm

0.0596 B

Spironolactone

25 mg, Tablet, Oral 100

0.0453 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Sulfacetamide Sodium

10%, Ointment, Ophthalmic 3.5 gm \$0.8100 B

10%, Solution/Drops, Ophthalmic 2 ml 0.7969 B

10%, Solution/Drops, Ophthalmic 5 ml 0.3300 B

10%, Solution/Drops, Ophthalmic 15 ml 0.1050 B

30%, Solution/Drops, Ophthalmic 15 ml 0.6000 M

Sulfadiazine

500 mg, Tablet, Oral 100 0.5513 B

Sulfamethoxazole; Trimethoprim

200 mg/5 ml; 40 mg/5 ml, Suspension, Oral 100 ml 0.0564 M

200 mg/5 ml; 40 mg/5 ml, Suspension, Oral 473 ml 0.0158 B

200 mg/5 ml; 40 mg/5 ml, Suspension, Oral 480 ml 0.0122 B

400 mg; 80 mg, Tablet, Oral 100 0.0711 B

800 mg; 160 mg, Tablet, Oral 100 0.0893 B

Sulfasalazine

500 mg, Tablet, Oral 100 0.1251 B

Sulfipyrazone

200 mg, Capsule, Oral 100 0.1643 B

100 mg, Tablet, Oral 100 0.1392 B

Sulfisoxazole

500 mg, Tablet, Oral 100 0.0788 B

Sulindac

150 mg, Tablet, Oral 100 0.2198 B

200 mg, Tablet, Oral 100 0.2963 B

Temazepam

15 mg, Capsule, Oral 100 0.0315 M

30 mg, Capsule, Oral 100 0.0405 M

Tetracycline Hydrochloride

250 mg, Capsule, Oral 100 0.0375 M

500 mg, Capsule, Oral 100 0.0578 B

Theophylline

80 mg/15 ml, Elixir, Oral 480 ml 0.0055 B

100 mg, Tablet, extended release, Oral 100 0.0630 B

200 mg, Tablet, extended release, Oral 100 0.0893 B

300 mg, Tablet, extended release, Oral 100 0.1125 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Thioridazine Hydrochloride

30 mg/ml, Concentrate, Oral 120 ml	\$0.1075 B
100 mg/ml, Concentrate, Oral 120 ml	0.4611 B
10 mg, Tablet, Oral 100	0.0300 M
15 mg, Tablet, Oral 100	0.0300 M
25 mg, Tablet, Oral 100	0.0338 M
50 mg, Tablet, Oral 100	0.0555 M
100 mg, Tablet, Oral 100	0.0900 M
150 mg, Tablet, Oral 100	0.1373 M
200 mg, Tablet, Oral 100	0.1538 M

Thiothixene

1 mg, Capsule, Oral 100	0.0975 B
2 mg, Capsule, Oral 100	0.1275 B
5 mg, Capsule, Oral 100	0.1823 B
10 mg, Capsule, Oral 100	0.2693 B

Thiothixene Hydrochloride

Eq. 5 mg base/ml, Concentrate, Oral 120 ml	0.2094 B
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Timolol Maleate

5 mg, Tablet, Oral 100	0.2022 B
10 mg, Tablet, Oral 100	0.2787 B
20 mg, Tablet, Oral 100	0.5639 B

Tobramycin

0.3%, Solution/Drops, Ophthalmic 5 ml	0.8070 B
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Tolazamide

100 mg, Tablet, Oral 100	0.0503 B
250 mg, Tablet, Oral 100	0.0938 B
500 mg, Tablet, Oral 100	0.1740 B

Tolbutamide

500 mg, Tablet, Oral 100	0.0458 B
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Tolmetin Sodium

Eq. 400 mg base, Capsule, Oral 100	0.2625 B
Eq. 600 mg base, Tablet, Oral 100	0.8813 B

Trazodone Hydrochloride

50 mg, Tablet, Oral 100	0.0697 B
100 mg, Tablet, Oral 100	0.1170 B
150 mg, Tablet, Oral 100	0.5843 B

GENERIC NAME

GENERIC UPPER

LIMIT /UNIT

SOURCE *

Triamcinolone Acetonide

0.025%, Cream, Topical 15 gm	\$0.0750 B
0.025%, Cream, Topical 80 gm	0.0328 B
0.025%, Cream, Topical 454 gm	0.0208 B
0.1%, Cream, Topical 15 gm	0.0740 B
0.1%, Cream, Topical 80 gm	0.0411 B
0.1%, Cream, Topical 454 gm	0.0392 B
0.5%, Cream, Topical 15 gm	0.1990 B
0.1%, Lotion, Topical 60 ml	0.1150 B
0.025%, Ointment, Topical 15 gm	0.0750 B
0.025%, Ointment, Topical 80 gm	0.0354 B
0.025%, Ointment, Topical 454 gm	0.0206 B
0.1%, Ointment, Topical 15 gm	0.0750 B
0.1%, Ointment, Topical 80 gm	0.0525 M
0.1%, Ointment, Topical 454 gm	0.0427 B
0.5%, Ointment, Topical 15 gm	0.2222 B
0.1%, Paste, Dental 5 gm	0.7650 B

Trifluoperazine Hydrochloride

Eq. 2 mg base, Tablet, Oral 100	0.4481 B
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Trihexyphenidyl Hydrochloride

5 mg, Tablet, Oral 100	0.3254 B
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Trimethoprim

100 mg, Tablet, Oral 100	0.1643 B
200 mg, Tablet, Oral 100	0.2438 B

Triple Sulfa (sulfabenzamide;sulfacetamide;sulfathiazole)

3.7%; 2.86%; 3.42%, Cream, Vaginal 78 gm	0.0510 B
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Tropicamide

0.5%, Solution/Drops, Ophthalmic 15 ml	0.2790 B
1%, Solution/Drops, Ophthalmic 2 ml	2.1375 B
1%, Solution/Drops, Ophthalmic 15 ml	0.3200 B

Valproic Acid

250 mg, Capsule, Oral 100	0.1298 B
250 mg/5 ml, Syrup, Oral 480 ml	0.0594 M

Verapamil Hydrochloride

40 mg, Tablet, Oral 100	0.2145 M
80 mg, Tablet, Oral 100	0.0518 B
120 mg, Tablet, Oral 100	0.0825 B
180 mg, Tablet, extended release, Oral 100	0.3825 B
240 mg, Tablet, extended release, Oral 100	0.3825 B

IM 6000. INPATIENT HOSPITAL AND LONG-TERM CARE REIMBURSEMENT

Congress enacted §4112 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), P.L. 100-203, which established minimum uniform criteria for you to follow in establishing methods for defining disproportionate share hospitals and determining payment adjustments to such hospitals. To comply with the requirements of §4112, determine whether you have a disproportionate share definition and payment methodology which meet the new criteria. If you are not in compliance, see §§6000.1 - 6000.5 for the necessary data and information sufficient to comply with the requirements of §4112.

IM 6000.1 Criteria for Deeming Hospitals Eligible for a Disproportionate Share Payment Adjustment--For purposes of complying with §4112, determine which hospitals can be deemed eligible for a disproportionate share payment adjustment. The definition must be incorporated in the plan. The following criteria of §4112(b) and (d) of OBRA 1987 must be met before a hospital is determined to be eligible:

A. Minimum Criteria--

1. A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low-income inpatient utilization rate exceeding 25 percent; and

2. The hospital must have at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A.2 does not apply to a hospital which:

- o The inpatients are predominantly individuals under 18 years of age; or
- o Does not offer nonemergency obstetric services as of December 21, 1987.

B. Definitions of Criteria

1. Medicaid inpatient utilization--For a hospital, the total number of its Medicaid inpatient days in a cost reporting period, divided by the total number of the hospital's inpatient days in that same period.

2. Low-income utilization rate--For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

- o Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

- o The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

C. Alternative Definition--Your plan may use another definition of the term "disproportionate share hospitals." However, the definition must include at least those hospitals which meet either of the definitions in subsections B.1 and B.2. Additionally, no hospital can be considered a "disproportionate share" hospital under a State's alternative definition unless it meets the requirement of subsection A.2.

IM 6000.2 Payment Adjustment--

A. Minimum Payment--The amount and formula for calculating the specified adjustment to payments made to disproportionate share hospitals must be included in the plan. Under §4112, the payment adjustment must at a minimum provide either:

1. An additional payment amount equal to the product of the hospital's Medicaid operating cost payment (e.g., DRG payment, per diem rate), times the hospital's Medicare disproportionate share adjustment percentage developed under rules established under §1886(d)(5)(F)(iv) of the Act, that can be paid to eligible hospitals. If you elect the Medicare disproportionate share calculation, the local Medicare fiscal intermediary has the data for determining the Medicare disproportionate share percentage; or

2. An additional payment amount (or increased percentage payment), which must be specified in the plan, and which must increase in proportion to the percentage by which the hospital's Medicaid utilization rate exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments.

B. Alternative Payment Adjustment--Your plan may use another formula for calculating the payment adjustment for disproportionate share hospitals. However, it must result in payment to each disproportionate share hospital of at least the minimum adjustment specified in subsections A.1. or A.2. to eligible facilities.

C. Phase In.--The payment adjustment will be phased in over a 3-year period. As of July 1, 1988, the adjustment must be at least one-third the amount of the full payment adjustment; as of July 1, 1989, the payment must be at least two-thirds the full payment adjustment; and as of July 1, 1990, you must pay the full amount of the payment adjustment.

IM 6000.3 State Requirements.--

A. Assurance or Statement by April 1, 1988.--To implement §4112, submit no later than May 15, 1988, either:

- o An assurance with the appropriate related information indicating compliance with §4112; or
- o A statement indicating that an amendment is necessary and will be submitted no later than July 1, 1988. If the plan uses an alternative definition of the term "disproportionate share hospital" or an alternative payment adjustment formula, submit along with the plan and its assurance, information which demonstrates that the applicable minimum criteria have been met.

B. Subsequent Assurance or Statement.--To achieve full implementation of §4112, you must submit no later than April 1, 1989, and April 1, 1990, respectively, either an assurance with the appropriate related information indicating continued compliance with §4112, or a statement noting the need for further amendment to comply with the phase-in of the payment adjustment.

6000.4 HCFA Approval or Disapproval.--Upon receipt of the assurance or amendment, we will review the State's submittal for compliance with §4112. For amendments submitted on or before April 1 of each year, HCFA's review must be completed, and the amendment must be approved or disapproved, by June 30. If disapproved, submit immediately an amendment complying with the statutory requirements of §4112. For amendments submitted after April 1 of each year with an effective date of July 1, HCFA will have 90 days in which to complete review of the amendment and approve or disapprove it.

IM 6000.5 Special Rule.--Your plan shall be considered to be in compliance with the disproportionate share hospital requirements of §1902(a)(13)(A) if you provided for payment adjustments for disproportionate share hospitals as of January 1, 1984, and if the aggregate amount of the hospital adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under §4112. If you wish to demonstrate compliance with §4112 under this provision, submit an assurance and the related information.

INTERIM STATE MEDICAID MANUAL INSTRUCTIONS 84 1**IM 6007. REVALUATION OF ASSETS**Statutory Requirements

Section 2314 of the Deficit Reduction Act (DEFRA) of 1984 amends the Federal requirements regarding reimbursement under Medicare and Medicaid for capital related costs. The Medicaid revision which adds section 1902(a)(13)(B) to the Act specifies that a State must provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of the Medicare requirements at section 1861(v)(1)(O) of the Act.

Section 1861(v)(1)(O), as revised by section 2314 of DEFRA, specifies that in establishing an appropriate allowance for depreciation, interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital or skilled nursing facility which has undergone a change of ownership, the valuation of the asset will be the lesser of the allowable acquisition cost of the asset to the first owner of record on or after July 18, 1984, or the acquisition cost of such asset to the new owner.

Implementation

As a result of the revised statutory requirements, States will now be required to submit a specific assurance regarding the State plan methodology as it pertains to reimbursement for capital related costs resulting from a change in ownership. The State must assure HCFA and demonstrate generally, that as a result of a change in ownership, the State plan will not increase payments to providers for depreciation, interest on capital and return on equity, in the aggregate, more than the amount that would be recognized under section 1861(v)(1)(O) of the Act. The provision does not apply to changes in ownership pursuant to an enforceable agreement entered into prior to July 18, 1984.

The assurances submitted by the State must be consistent with the specific provisions of the State plan methodology as it affects reimbursement for depreciation, interest, and return on equity. In certain instances, a State plan may require an amendment to revise the State's current methodology in order to comply with the statutory provision.

Effective Dates

1. **Change of Ownership** - The provisions of section 2314 of DEFRA are applicable to all changes of ownership which occur on or after July 18, 1984, except for those changes made pursuant to an enforceable agreement executed prior to that date.
2. **Assurances**
 - a. A State that provides in its State plan methodology that it follows Medicare principles of reimbursement as they apply to capital-related costs must comply with all applicable Medicare requirements

in effect in the applicable rate period. This would also apply to those States that cite the Medicare principles (HCFA-Pub. 15) in determining asset value in conjunction with various other adjustments or limitations to that methodology (e.g., occupancy limits, per diem capital limits, etc). Accordingly, States which cite the Medicare principles, and wish to continue to follow those principles, must submit the assurance required by section 1902(a)(13)(B) as it applies to medical assistance furnished on or after July 18, 1984.

- b. A State that provides in its State plan methodology for the reimbursement of capital related costs without citing the Medicare principles must apply this provision to payments to facilities for medical assistance furnished on or after October 1, 1984. The State must provide an assurance that, payments for medical assistance furnished on or after October 1, 1984, cannot reasonably be expected to increase solely as a result of a change in ownership, in excess of the increase which would result from applying section 1861(v)(1)(O) of the Act, to owners of record on July 18, 1984.

Where a change to the existing State plan methodology cannot be effectuated without a State legislative change, the State plan will not be held out of compliance solely on the basis of its failure to meet these requirements prior to the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature which begins after July 18, 1984. However, although the State plan change may be delayed for this reason, the provision will ultimately be applied to the acquisition costs of new owners of record on or after July 18, 1984.

State Actions

Accordingly, States must take the following actions by December 31, 1984, or upon submittal of an amendment to its inpatient hospital or long-term care reimbursement plans, whichever is earlier, as applicable, to comply with the revised statutory requirements for reimbursement for depreciation, interest on capital indebtedness and return on equity capital under Medicaid:

1. State plan methodology cites the Medicare principles for determining allowable capital-related costs and;

- a. The State will continue with the Medicare methodology

The State must submit an assurance that it will not exceed the Medicare statute at 1861(v)(1)(O).

- b. The State desires to amend the State plan methodology for reimbursement of capital-related costs

The State must submit an approvable State plan amendment, and the assurances required under section 1902(a)(13)(A) and the assurances required under section 1902(a)(13)(B) of the Act, which requires that the State assure and demonstrate generally, that the payment methodology used by the State for medical assistance beginning October 1, 1984, can reasonably be expected not to increase

payments solely as a result of a change of ownership in excess of the increase which would result from applying 1861(v)(1)(O) of the Act, as applied to owners of record on July 18, 1984; or

2. The current State plan methodology reimburses for capital-related costs with no reference to Medicare principles, and;

a. State does not need to amend its plan in order to provide the assurance:

The State must submit the assurance required by section 1902(a)(13)(B) for medical assistance beginning October 1, 1984, as applied to owners of record on July 18, 1984, which requires that the State assure and demonstrate generally, that the payment methodology used by the State for medical assistance beginning July 18, 1984, can reasonably be expected not to increase payments solely as a result of a change of ownership in excess of the increase which would result from applying 1861(v)(1)(O) of the Act, as applied to owners of record on July 18, 1984; or

b. State is required to amend the plan methodology to provide assurance:

The State must submit an approvable State plan amendment, and all of the assurances required under sections 1902(a)(13)(A) and (B) of the Act, which requires that the State assure and demonstrate generally, that the payment methodology used by the State for medical assistance beginning October 1, 1984, can reasonably be expected not to increase payments solely as a result of a change of ownership in excess of the increase which would result from applying 1861(v)(1)(O) of the Act, as applied to owners of record on July 18, 1984. However, if the State requires legislation in order to amend the State plan, the State agency must submit to HCFA a written statement that pursuant to the opinion of the appropriate State legal authority, the required plan amendment may not be effectuated without a State legislative change. The statement should also advise HCFA of the date of the close of the first regular session of the State legislature after July 18, 1984. The State will be required to submit the required assurance by the end of the calendar quarter following that date.

Assessment of Compliance

State compliance with the statutory provision will be reviewed under the State assessment process. The HCFA Regional Office will review the State's implementation of the revaluation of assets provision for consistency with the approved State reimbursement plan and for compliance with Federal requirements, and review the State's demonstration that payments have not increased in the aggregate solely because of a change of ownership in excess of the increase that would have been permissible under the Medicare principles for revaluation of assets.

For further information or if you have any questions about this transmittal, please contact Tzvi Hefter, 1-A-1 East Low Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21235, or call (301) 597-1808.